| EPARTMENT OF HEALTH AND HUMAN SERVICES | | | | | | | |
|--|---------------------------------------|----------------------------|------|--|--|--|--|
| CENTERS FOR MEDICARE & MEDI | TERS FOR MEDICARE & MEDICAID SERVICES | | | | | | |
| STATEMENT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|--|---------|--------------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 15E359 | B. WIN | I 06/14/2011 | | | |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | PREFIX | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0000 | | | | | | | |
| F0000 | state licensure suring an extended suring peopardy. Survey dates: Jun 13, 14, 2011 Facility number: Provider number Aim number: 100 Survey team: Amy Wininger, H. Diane Hancock, Survey team: August 100 Census bed type: NF: 42 Total: 42 Census payor type Medicaid: 41 Other: 1 Total: 42 Sample: 11 Supplemental samples | ne 6, 7, 8, 9, 10, 11, 12, 000443 :: 15E359 0289580 RN TC RN | F0 | 000 | | | |
| | | accordance with 410 IAC | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11

Facility ID:

000443

TITLE

| l ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E-350 | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/14/2011 | |
|--------------------------|--|---|---------------------------------|--|--|----------------------|
| | PROVIDER OR SUPPLIER | | 1236 L | ADDRESS, CITY, STATE, ZIP CODE INCOLN AVENUE SVILLE, IN47714 | 00/14/2 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ompleted 6/19/11 RN | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F0241 SS=D | a manner and in a maintains or enhal and respect in full individuality. Based on observation interview, the fact 10 current sample sample of 11, was maintain her dign washed the reside instead of obtains (Resident #12) Finding includes On 6/8/11 at 5:20 #2 were observed the restroom. The incontinent of a sand a smear of both brief. The reside and changed. Wassisted to walk be incontinent of urbrief. The CNAs removed the soile wet and soapy brithe bathroom. The | | F0241 | Mandatory in-services we for all nursing employees 14 and June 20, 2011, ad peri-care procedures and of preservation of dignity. will be monitored five time week for one month as the provide peri-care. After the month, twice a week CNA randomly selected and of the CNAs will be monitor the charge nurse, ADON DON. All new employees in-serviced on peri-care define the orientation process, a ongoing bi-annual in-serviced on peri-care define orientation of dignit ongoing monitoring for or | on June dressing review CNAs es a ey ne first s will be served. ed by and will be uring nd cing will peri-care | 06/30/2011 |

000443

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| l | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | li i | E SURVEY PLETED '2011 |
|--------------------------|---|---|--|---|--------|-----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP COI NCOLN AVENUE VILLE, IN47714 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| | 1 ~ | uring interview at that ated, "No wash cloths, e." | | | | |
| | reviewed with the During interviewed with the During interviewed with the During interviewed wash cloths." The policy and put Care, dated 7/200 Director of Nursep.m. The proceed limited to, the for supplies: a. Glo | D p.m., the above was e Director of Nurses. At that time, she stated, should have gone and got rocedure for Perineal D5, was provided by the sing on 6/13/11 at 12:10 dure included, but was not sllowing: "Assemble eves, b. Wash cloth and ash' or soap and basin of tissue." | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 06/14/2011 | | |
|--|---|---|--|--|--|
| | PROVIDER OR SUPPLIER | | STREET | ADDRESS, CITY, STATE, ZIP CODE INCOLN AVENUE IVILLE, IN47714 | |
| (X4) ID PREFIX TAG F0279 | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) the results of the | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE |
| SS=D | assessment to developed and deto be provided rehydration, for 2 or regards to activit and 1 of 3 sample hydration, in the #41). Findings include The facility must do care plan for each measurable object a resident's medic psychosocial needs comprehensive as The care plan must are to be furnished resident's highest mental, and psych required under §44 would otherwise be but are not provide exercise of rights or right to refuse treat Based on intervite facility failed to developed and deto be provided rehydration, for 2 or regards to activitiand 1 of 3 sample hydration, in the #41). Findings include 1. The clinical rewas reviewed on The most recent of the sample hydration of the most recent of the sample hydration. | evelop, review and revise the nensive plan of care. evelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and its that are identified in the sessment. St describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). The wand record review, the ensure care plans were escribed specific services garding activities and of 11 sampled residents in ites (residents' #28, #9), and residents reviewed for sample of 11 (resident | F0279 | All care plans have been reviewed with regard to hydra and the care plans have bee updated with specific interventions. The care plans be reviewed quarterly, or with change of condition, and updas needed. All residents have been assessed for signs and symptoms of dehydration, an interventions initiated as needed. All residents will be assessed signs and symptoms of dehydration and intervention initiated if indicated. Resider will be assessed weekly for sand symptoms of dehydration documented in the weekly summary. In-services for all nursing staff were held on July 23, June 24, June 27, and witheld on July 1, 2011, address | n s will h dated //e dated ded. dd for s hts signs n and line ill be |

| li ' | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|------------|---|------------------------------|----------------------------|--|---|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | | |
| | | 15E359 | B. WIN | G | | 06/14/2 | 011 | |
| NAME OF | PROVIDER OR SUPPLIER | 3 | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | | |
| TO LINE OF | I NO VIDER OR SOIT EIEI | | | 1 | NCOLN AVENUE | | | |
| ST JOH | NS HOME FOR THE | EAGED | | EVANS' | VILLE, IN47714 | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | care plan. | | | | interventions to prevent | | | |
| | | | | | dehydration. The MDS coordinator and DON will mo | nitor | | |
| | 2. The clinical r | ecord of Resident #9 was | | | the care plans and interventi | | | |
| | reviewed on 06/9 | 07/11 at 11:15 A.M. | | | Ongoing monitoring for one | | | |
| | | | | | Completed date: 07/08/11 | he | | |
| | The most recent | care plan, dated 05/16/11, | | | Activity Director was in-servi | | | |
| | | mentation of an activity | | | on June 24, 2011 on care pla | | | |
| | care plan. | | | | problems, measurable goals | | | |
| | care plan. | | | | specific interventions. Activity care plans on all residents have | | | |
| | In an interview with the Activity Director | | | | been developed according to | | | |
| | In an interview with the Activity Director | | | | resident's personal interest, | | | |
| | [AD], on 06/10/11 at 10:30 A.M., she indicated, "There is no activity care plan | | | | of cognition and physical and | | | |
| | 1 | , , | | | mental ability. The care plan | ıs | | |
| | 1 - | sident #9] or [name of | | | have measurable goals and specific interventions. The ca | aro | | |
| | Resident #28]." | | | | plans will be reviewed and | ai C | | |
| | | | | | updated quarterly or with cha | ange | | |
| | | | | | of condition. The MDS | 3 - | | |
| | | | | | Coordinator will review activi | • | | |
| | | | | | care plans at each care plan | | | |
| | | | | | review for specific goals and | | | |
| | | | | | interventions. Ongoing monit for one year. Completed date | | | |
| | | | | | 07/14/11 | . | | |
| | 3. Resident #41 | 's clinical record was | | | | | | |
| | | /11 at 2:35 p.m. The | | | | | | |
| | | oses included, but was not | | | | | | |
| | | ic kidney disease, | | | | | | |
| | 1 | d congestive heart failure. | | | | | | |
| | 1 ** | rs, signed 5/19/11, | | | | | | |
| | 1 | | | | | | | |
| | 1 | ere not limited to, the | | | | | | |
| | following medication: Demadex | | | | | | | |
| | [diuretic]. | | | | | | | |
| | Resident #41's o | nly care plan regarding | | | | | | |
| | fluids was as fol | | | | | | | |
| | | | | | | | | |
| | [Kesident's nam | ne] has the potential for | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| l | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | li i | E SURVEY PLETED 2011 |
|--------------------------|--|--|--|---|---------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | NDDRESS, CITY, STATE, ZIP CO NCOLN AVENUE VILLE, IN47714 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | med use and diag [congestive hear edema and renal] The only interver following: "-Give [Resident [milligrams] PO MD orders, provesoft), monitor for fluid deficit/over edema, dry mout urinary output et -Give [resident's chloride 10 meq daily." The care plan lact interventions to prove the state of the | a, PO [by mouth] diuretic gnoses of CHF t failure], pulmonary insufficiency." Intions included the distributed standard symptoms of cload (tenting skin, ch, increase/decrease in | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E-350 | | A. BUILDING 00 | | COMPL | COMPLETED | | |
|---|---|--|---------|---------|---|---|------------|
| | | 15E359 | B. WING | G | | — 06/14/2011 | |
| | ROVIDER OR SUPPLIER | | • | 1236 LI | NDOLN AVENUE VILLE, IN47714 | | |
| (X4) ID | SUMMARY S' | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENC | H DEFICIENCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | TE . | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0280 SS=D | The resident has the incompetent or othe incapacitated under participate in plant changes in care at the A comprehensive of developed within 7 of the comprehensive of the comprehensive of the comprehensive in the participate of the physicial responsibility for the appropriate staff in by the resident's in practicable, the participate of the participate | the right, unless adjudged herwise found to be ear the laws of the State, to hing care and treatment or and treatment. Care plan must be a days after the completion sive assessment; prepared hary team, that includes the n, a registered nurse with the resident, and other and disciplines as determined eeds, and, to the extent articipation of the resident, lay or the resident's legal diperiodically reviewed and of qualified persons after attion, interview, and the facility failed to ensure eviewed and revised the sample of 11. The sample of 11. Which with the DoN [Director 6/06/11 at 10:10 A.M., | F0 | 280 | New fall assessments have to completed on all residents. A each fall, current intervention be reviewed and new interventions initiated relating the fall. If the fall prevention interventions are ineffective, interventions will be initiated. interdisciplinary falls committ will meet weekly to discuss residents that have fallen, cuinterventions, and new place interventions. All care plans falls have been reviewed and updated. The MDS / Care Pland Coordinator has been in-serviced addressing updating and revior care plans with specific fall prevention interventions and revision of ineffective interventions. Mandatory in-services will be held on Ju | ofter is will g to new An eee rrent d for d lan viced ising I | 07/11/2011 |
| | | | | | July 6, July 7, and July 8, 20 | 11, | |

000443

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE COMPI 06/14/2 | LETED |
|--|---|---|--|---|----------------------|
| NAME OF PROVIDER OR SUPPLIEST JOHNS HOME FOR TH | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | |
| PREFIX (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE DEFICIENCY) | O BE | (X5) COMPLETION DATE |
| The May 2011 indicated Residincluded, but we lower extremity. The most curre Set Assessment indicated Residing assist of one for experienced two assessment. The most recent 05/16/11, indic "potential for 03/04/11 [line is handwritten not care plan interves frequently used Resident #9] ear of Resident #9] Resident #9] Resident #9] Resident #9] to transfer/ambula [name of Residicall light,ens is wearing apprensure [name of clutter,MI medication revealed 05/27/11 [Complete block [Complete Metical content of the complete of the | Physician's Recap ent #9's diagnoses ere not limited to, chronic | IAU | for all nursing employees in-services will address t pad alarms correct usag Residents with alarms in will be checked each shi correct placement of ala alarm box. Alarm assess will be completed quarte needed. Ongoing monito one year. The charge nu ADON and DON will more | ab and e. place ft for m and ments rly and as ring for rse, | DATE |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | (X3) DATE S COMPL | | |
|--|---|---|-------------------|------------------|--|---------|--------------------|
| | | 15E359 | A. BUII B. WIN | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | | | STREET A | NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | ΓE | (X5) COMPLETION |
| TAG | documentation of any updated | | | TAG | DEFICIENCY) | | DATE |
| | interventions to p | prevent further falls. | | | | | |
| | P.M., indicated, 'room via a CNA Assistant]; found parallel with lour bathroom door' | es, dated 12/10/10 at 8:45 'Summed [sic] to the [Certified Nursing resident lying on a quilt nger and head facing ' The Nurse's Notes and any documentation of rventions to prevent | | | | | |
| | P.M., indicated, 'family member n member] that the floor" An addit same date at 8:00 resident on the fl | es, dated 12/17/10 at 5:15 'Another residents [sic] ottified [name of staff resident was on the ional Nurses's Note the O.P.M. indicated, "Found oor in the middle of the t sideGrippy sock | | | | | |
| | at 2:00 P.M., she intervention of G on the care plan a passed on verball DoN further indidocumentation to been applied rout | with the DoN, on 06/07/11 indicated the rrippy socks was not put and should have been by from shift to shift. The cated there was no prove Grippy socks had tinely since the fall. | | | | | |
| ı | | 'calling for help, found | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11 Facility ID:

000443 If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE COMPI 06/14/2 | LETED | |
|--|---|--|--------|---------------------|---|-------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Nurse's Notes lac | way entrance" The eked any documentation atterventions to prevent | | | | | |
| | P.M., indicated, CNA Resident w supine position getting ready for edge of the bed a Resident was bar were applied beforms and the Nurse's Note P.M., indicated, room. Resident of toilet" The Nu lacked any updat prevent further farms and the p.M., indicated, feet toward her beforms aid she hit her helacked any updat prevent further farms aid she hit her helacked any updat prevent further farms. | es, dated 03/04/11 at 6:50 l'Heard yelling from her in the floor in front of the rise's Notes and care plan ed interventions to alls. s, dated 03/05/11 at 4:50 l'was on the floor with ed sitting on he he slid out of bedshe ead" The nurse's notes ed interventions to | | | | | |
| | care plan lacked | The Nurse's notes and any updated | | | | | |

000443

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) M A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|---|---|--|----------|----------------|---|------|------------|
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIEF | ₹ | | 1236 LII | NCOLN AVENUE | | |
| ST JOHNS HOME FOR THE AGED | | | | EVANS' | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | COMPLETION |
| TAG | + | , | <u> </u> | TAG | DLI ICILICI I | | DATE |
| | interventions to | prevent further falls. | | | | | |
| | The Nurse's Not | es, dated 05/27/11 at 3:40 | | | | | |
| | | " Resident sitting on | | | | | |
| | 1 | recliner"The Nurse's | | | | | |
| | notes and care pl | | | | | | |
| | documentation of | - | | | | | |
| | 1 | prevent further falls. | | | | | |
| | 1 | • | | | | | |
| | In an interview with the DoN on 06/07/11 | | | | | | |
| | at 1:00 P.M., she indicated she would not | | | | | | |
| | be able to provide documentation of | | | | | | |
| | specific interventions for each fall. She | | | | | | |
| | further indicated | she would check the lab | | | | | |
| | book to see if lat | os were done" | | | | | |
| | On 06/07/11 at 3 | 2:00 P.M., the DoN | | | | | |
| | provided a timel | | | | | | |
| | 1 * | Resident #9. The | | | | | |
| | | ed, "For fall 03/04/11 and | | | | | |
| | | medication] reviewFor | | | | | |
| | | ourageto request assist | | | | | |
| | 1 | nbulationFor Fall | | | | | |
| | | complete blood count] | | | | | |
| | 1 | metabolic panel]." | | | | | |
| | | J. | | | | | |
| | 2. Resident #28 | 's clinical record was | | | | | |
| | reviewed on 6/7/ | /11 at 3:25 p.m. The | | | | | |
| | 1 | nitted to the facility on | | | | | |
| | | gnoses including, but not | | | | | |
| | 1 | eimer's Disease and | | | | | |
| | 1 | ne resident's last full | | | | | |
| | 1 ^ | Set [MDS] assessment, a | | | | | |
| | 1 | ge assessment, was dated | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) M A. BUII | | NSTRUCTION 00 | (X3) DATE (COMPL 06/14/2 | ETED | |
|--|----------------------|------------------------------|--------|---------------|--|---------|------------|
| | | 100009 | B. WIN | | PRESIDENCE CONTROL CON | 00/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE | | |
| ST JOHN | NS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΤE | COMPLETION |
| TAG | † | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | | sessment indicated the | | | | | |
| | 1 | l total assistance of two | | | | | |
| | | s, and was unable to | | | | | |
| | | ssessment indicated he | | | | | |
| | | ne previous assessment, | | | | | |
| | | The assessment indicated | | | | | |
| | he utilized bed ra | ails. | | | | | |
| | Resident #28's S | ide Rail Assessment, | | | | | |
| | dated 3/17/11, in | dicated the resident had | | | | | |
| | fluctuations in le | evels of consciousness or | | | | | |
| | a cognitive defic | it related to a dementia | | | | | |
| | diagnosis, had vi | isual deficits, was able to | | | | | |
| | get in/out of bed | , was not able to get out | | | | | |
| | - | d a history of falls, used | | | | | |
| | 1 | elp rise from a supine | | | | | |
| | | ng/standing position, had | | | | | |
| | 1 ^ | climb over the side rails, | | | | | |
| | | ridence the resident had a | | | | | |
| | | to get out of bed, | | | | | |
| | | ng. The recommendations | | | | | |
| | | Frails to serve as an | | | | | |
| | 1 | ote independence. | | | | | |
| | | r | | | | | |
| | The resident's Pe | ersonal Alarm Assessment | | | | | |
| | | 1. It indicated the date of | | | | | |
| | | 18/11 and a history of | | | | | |
| | | The assessment failed to | | | | | |
| | 1 ^ | behaviors" of trying to | | | | | |
| | | walk alone, or trying to | | | | | |
| | · · | safely. The assessment | | | | | |
| | 1 ~ | olems with walking, | | | | | |
| | 1 ^ | ng, communication, and | | | | | |
| | 1 | • | | | | | |
| | Leognitive ability | . The determination was | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S COMPLI | | |
|---|-----------------------|---|------------|--------------|--|----------|--------------------|
| AND PLAN | OF CORRECTION | 15E359 | A. BUI | LDING | 00 | 06/14/20 | |
| | | 10000 | B. WIN | | | 00/14/20 | 711 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST IOHN | IS HOME FOR THE | AGED | | 1 | NCOLN AVENUE VILLE, IN47714 | | |
| | | | | | VILLE, IIN+1114 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | `` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | DATE |
| | | o have a tab alarm at all | <u> </u> | | | | D.III.D |
| | times. | o nave a tao alami at an | | | | | |
| | times. | | | | | | |
| | Resident #28's ca | are plan was reviewed by | | | | | |
| | | /22/11. The care plan for | | | | | |
| | l * | /16/11, indicated a | | | | | |
| | | vas to be used for the | | | | | |
| | | rs. Resident #28 had a | | | | | |
| | | ows: "[Resident's name] | | | | | |
| | is a fall risk relate | | | | | | |
| | | cal limitations and urinary | | | | | |
| | • • • • | ast documented fall: | | | | | |
| | | rventions included the | | | | | |
| | | iventions included the | | | | | |
| | following: | to plant staff of attaining | | | | | |
| | | to alert staff of attempts sfer unassisted. Place | | | | | |
| | | | | | | | |
| | | ip out of [resident's] | | | | | |
| | reach to ensure p | nent to determine need | | | | | |
| | for continued ala | | | | | | |
| | | | | | | | |
| | I = | nt] staff assist with | | | | | |
| | transfers/toileting | | | | | | |
| | - | t] is wearing appropriate, | | | | | |
| | non-slip footwea | | | | | | |
| | | ident's] frequently used | | | | | |
| | items are within | casy icacii. | | | | | |
| | Davious of Docid | ent #28's nurses' notes | | | | | |
| | | | | | | | |
| | | re not limited to, the | | | | | |
| | following: | ICNIA a mealan me in the | | | | | |
| | 1 ^ | 'CNAs make rounds | | | | | |
| | | ying half way on the | | | | | |
| | | esident on stomach | | | | | |
| | [[with] head turne | ed to (R) [right] side and | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11 Facility ID:

000443

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | | | | LDING | NSTRUCTION 00 | (X3) DATE: COMPL 06/14/2 | ETED |
|---|---|---|---|---------------------|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1 | STREET A | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | πE | (X5) COMPLETION DATE |
| | laying on his arm [with] (R) leg sti alarm. Able to red places on (R shoulder. Assistiii [three] staff m when (R) leg wa alarm went off. lowest position halarm working p written by a Qua Assistant [QMA 1/18/11 10:15 p. 156/90 P [pulse] [temperature] 98 [saturation] 95% [Sister] [name of notified, messag POA [Power of 1/18/11 10:50 p. fax regarding fal 1/19/11 12:00 a.: [within normal lip 68 R 18 02 sat awakens easily, 2/4/11 11-7 "Resattempting to get several times ear discomfort. CarofferedAlarm 13/15/11 11:30 p.: awake, in bed [within power of 1/18/11 11:30 p.: awa | n. (L) [left] leg on floor ll on the bed, on pad nove all extremities. Has) forehead, cheek and (R) ed up [with] gait belt and nembers. At that time, s removed from bed, Resident bed was in nad on gripper socks and roperly." The note was lified Medication]. m. "B/P [blood pressure] 70 R [respirations] 20 T .3 02 [oxygen] sat on RA [room air]. Sr. f Nun Supervisor] e left on answering for Attorney]." QMA note. m. "Dr. [name's] office l on resident." QMA note m. "Neuro [checks] WNL limits] B/P 148/80 T. 97.5 r. 95% on RA. Resident Denies discomfort" | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | COMPI | | |
|---|----------------------|------------------------------|--------|---------------|--|---------|------------|
| | | 15E359 | - 1 | LDING | | 06/14/2 | |
| | | | B. WIN | | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCT) | | DATE |
| | 1 | a. "A little restless @ | | | | | |
| | ~ ~ | ft, trying to climb out of | | | | | |
| | | om. CNAs assist [with] | | | | | |
| | • | resident up. Toileted and | | | | | |
| | 1 ^ | hair. Much calmer. | | | | | |
| | ~ | on area watching T.V" | | | | | |
| | 1 | m. "Resident observed | | | | | |
| | ' ' | de of bed. Assisted | | | | | |
| | | gs back on bedalarm in | | | | | |
| | place." | esident has been observed | | | | | |
| | | out of bed @ X's [at | | | | | |
| | , , , | Legs off side of bed, | | | | | |
| | | ped. Denies discomfort. | | | | | |
| | | | | | | | |
| | Alarm remains in | "Tab alarm set off found | | | | | |
| | 1 ^ | ower body on (R) knee | | | | | |
| | | body in bed. (R) knee | | | | | |
| | | er bruises or O/A [open | | | | | |
| | | Assist back to bed tab | | | | | |
| | 1 - | 40/78 T 98.8 P 93 R 20 | | | | | |
| | | n air. Has been more | | | | | |
| | confused though | | | | | | |
| | | ı. "CNA observed | | | | | |
| | 1 | to put legs over side of | | | | | |
| | | t back to bed. Tab alarm | | | | | |
| | in place." | | | | | | |
| | _ | . "Dr. [name] notified | | | | | |
| | fax and Sr.[Siste | | | | | | |
| | Supervisor] notif | | | | | | |
| | | . "Resident trying to | | | | | |
| | climb out of bed | | | | | | |
| | | i. "Once in bed, tried X | | | | | |
| | _ | ed. Alarm in place and | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) N | IULTIPLE CO | NSTRUCTION | | (X3) DATE | |
|------------|--|------------------------------|--------|-------------|--------------------|--|-----------|--------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BU | LDING | 00 | | COMPL | |
| | | 15E359 | B. WIN | | | | 06/14/2 | U11 |
| NAME OF I | PROVIDER OR SUPPLIEF | | | | DDRESS, CITY, STAT | | | |
| OT IOU | IO LIOME FOR THE | ACED | | 1 | NCOLN AVENUE | | | |
| | IS HOME FOR THE | | | <u> </u> | VILLE, IN47714 | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | | AN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | CROSS-REFERENCED | ACTION SHOULD BE O TO THE APPROPRIAT CIENCY) | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFIC | SIENC I) | | DATE |
| | working properly | • | | | | | | |
| | 1 | n. "Found resident on the | | | | | | |
| | . • | th] back up against the | | | | | | |
| | | the (R) [with] head | | | | | | |
| | | side rail. Bed in low | | | | | | |
| | 1 ^ | nonitor on and did not | | | | | | |
| | •• | range of motion] adeq. | | | | | | |
| | [adequate] to all | | | | | | | |
| | 1 | n. "Attempting to climb | | | | | | |
| | out of bed X 2. | Set tabs monitor off. | | | | | | |
| | Wanting to go fis | shing" | | | | | | |
| | 6/4/11 2:45 a.m. | "During routine bed | | | | | | |
| | check, resident of | observed sitting upright on | | | | | | |
| | floor beside bed. | Bed in lowest position. | | | | | | |
| | Alarm still attacl | hed, did not pull away to | | | | | | |
| | sound. AROM [| active range of motion] | | | | | | |
| | · | vithout] difficulty. | | | | | | |
| | - | ort. B/P 124/70 T 98 P 76 | | | | | | |
| | | % RA. Assisted to | | | | | | |
| | | n per (3) assist and gait | | | | | | |
| | • • | bed. [No] redness noted | | | | | | |
| | | ick. Alarm positioned to | | | | | | |
| | | bed and attached to | | | | | | |
| | * * | hirt. Encouraged call | | | | | | |
| | light use." | int. Difoundou can | | | | | | |
| | ngiit use. | | | | | | | |
| | There was no inc | dication the care plan was | | | | | | |
| | revised when the | - | | | | | | |
| | interventions we | _ | | | | | | |
| | interventions we | 10 1110110011 v 0. | | | | | | |
| | 3 Resident #30' | 's clinical record was | | | | | | |
| | | /11 at 12:07 p.m. The | | | | | | |
| | | | | | | | | |
| | resident's diagnoses included, but were not limited to, Parkinson's disease, | | | | | | | |
| | | • | | | | | | |
| FORM CMS-2 | 2567(02-99) Previous Version | ons Obsolete Event ID: | 5LWB11 | Facility I | D: 000443 | If continuation sh | eet Pa | ge 16 of 122 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | ľ | E SURVEY PLETED (2011 | |
|--|---|---|---------------------|---|-----------------------------|----------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP CO INCOLN AVENUE SVILLE, IN47714 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| | dementia, osteop spinal stenosis, c pulmonary diseas. The resident's mode Minimum Data Stated 4/21/11, in required extensive transfers and ambigable since the last resident's most reassessment was condicated the resident expresses side rails. The resident expresses side rails raised from and/or comfort, hof consciousness had visual deficit of bed safely, had the side rails for had not attempted rails, had evidence a desire or reason nocturnal toileting that would require antidepressant and Resident #30's capotential, dated 4 resident's last door and the side of the side rails for the side rails | enia, osteoarthritis, hronic obstructive se, and hypertension. ost recent quarterly set [MDS] assessment, dicated the resident re assistance of 1 for bulation, and had not had at assessment. The event Fall Risk stated 4/20/11 and dent was at high risk for int's Side Rail and 4/21/11, indicated the red a desire to have the for their own safety had fluctuations in levels or a cognitive deficit, as, was unable to get out da history of falls, used positioning and support, and to climb over the side of the resident may have in to get out of bed due to ag, and had medications are safety precautions, an | | | | |
| | - | anical lift for transfers | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11

Facility ID:

000443

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | ` ′ | e survey Pleted /2011 | |
|--|--|--|---------------------|--|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP C NCOLN AVENUE VILLE, IN47714 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE I DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | when [resident] is Encourage [resident] with transfers/and wheelchair for locallow [resident] is task as able. Pade chair and wheelch attempts to ambuture [resident non-slip footweath - Transfer [resident n | s unable to stand. ent] to request assistance abulation. Utilize ang-distance locomotion. To perform as much of alarm in place to bed, hair to alert staff of alate/transfer unassisted. To is wearing appropriate and she is able/willing to bear abs per MD orders. The staff are of clutter also are within of [resident's] bed is up of [resident's] bed is up and the she is able/willing to bear abs per MD orders. T | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | ONSTRUCTION 00 | (X3) DATE : COMPL | | |
|---|----------------------|------------------------------|--------|-----------------|---|---------|------------|
| 111,1212111 | or condition | 15E359 | | LDING | | 06/14/2 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | 1 | m. "B/P [blood pressure] | | | | | |
| | | rature] 97.1 P [pulse] 88 | | | | | |
| | • • | 20 O2 [oxygen] sat | | | | | |
| | - | on RA [room air]. | | | | | |
| | Denies discomfo | | | | | | |
| | | . "Heard noise in hallway | | | | | |
| | | om. Staff to area. | | | | | |
| | | ed in hallway outside of | | | | | |
| | · · | in her wheelchair. | | | | | |
| | Rolling walker be | | | | | | |
| | | nt's night gown to be on | | | | | |
| | · · | re strings tied. Alarm | | | | | |
| | observed on bed. | | | | | | |
| | | to/from bathroom, skin | | | | | |
| | | ipper socks [changed], | | | | | |
| | | sted back to bed. alarm | | | | | |
| | | ain reminded resident to | | | | | |
| | _ | ace and to use call light | | | | | |
| | PRN assist" | | | | | | |
| | 1 | . "Had been in bed about | | | | | |
| | | she was found on the | | | | | |
| | floor beside her b | ped." | | | | | |
| | _ | n. "Had been returned to | | | | | |
| | ' ' | larm on as before. Now | | | | | |
| | 1 | gain. Had pulled blanket | | | | | |
| | up straight on be | d. Gown was on | | | | | |
| | | s magnet was clipped to | | | | | |
| | itself so that it we | ould not sound." | | | | | |
| | | n. "Resident [up] in | | | | | |
| | recliner by TV or | n Holy Family Unit as to | | | | | |
| | be under watchfu | ıl eyes. Tab alarm on (L) | | | | | |
| | [left] side as usua | al clipped to gown. | | | | | |
| | Second alarm cli | pped to (R) [right] side | | | | | |
| | and pinned also, | she is @ this time | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11 Facility ID:

000443

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | | A. BUILDING | CONSTRUCTION 00 | li i | E SURVEY PLETED //2011 | |
|---|---|--|-----------------|--|------------------------|----------------------|
| | PROVIDER OR SUPPLIER | | 1236 | TADDRESS, CITY, STATE, ZIP (LINCOLN AVENUE ISVILLE, IN47714 | - | |
| | SUMMARY S (EACH DEFICIENT REGULATORY OR unaware of 2nd t 4/25/11 3-11 p.m SummaryTook without it soundir and was seen and 6/4/11 7:15 p.m. recliner. Has sou up wanting to do Are monitoring of the monitoring of the bedside. The alarm box wanything to stabilitatempted to get at the was no independent of the resident of the reside | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ab alarm." "Weekly tabs alarm off once ing and sat on side of bed d toileted per staff" "Resident now in inded alarm X 4 getting things independently. Plosely." D a.m., Resident #30 was eated in her recliner chair the tabs type alarm box he arm of the chair to the ent. The string was hident's right shoulder. as not attached to lize it if the resident hup. Lication the facility rised the care plan when | 1236 | LINCOLN AVENUE | ORRECTION SHOULD BE | (X5) COMPLETION DATE |
| | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | (X3) DATE S COMPL | | |
|--|--|--|-----------------------|-----------------|--|--|----------------------------|
| | | 15E359 | A. BUILDIN B. WING | NG | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER S HOME FOR THE | | S 1 | 236 LIN | DDRESS, CITY, STATE, ZIP CODE ICOLN AVENUE IILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PRI | D EFIX AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | (X5) COMPLETION DATE |
| F0281 SS=D | facility must meet quality. During observation review, the facility gastrostomy tube staff in accordance standards, for 1 of with a gastrostom 11, in that proceed to ensure placement feeding and/or mand sufficient fluf administered. (Refindings include: Upon interview of the medication parameter of the medic | during and observation of ass, on 06/08/11 at 12:00 cated she was preparing dications and feeding tomy [g-tube]. RN #1 P (Tylenol) 20 ml mg [milligrams] and dication cup. RN #1 | F028 | | New Policy and Procedures and adopted regarding tube feeding and medication administration with G-tubes. Mandatory in-services were held on June June 24, June 27, and will be on July 1, 2011, to review the policies. All nurses and QMA have given a return demonstration of tube feeding and medication administration the completion date. Any new hires will be in-serviced during their orientation. Ongoing in-services will occur quarter Nurses and QMAs will be observed one time daily for omonth, and then they will be observed weekly for correct administering of tube feeding medication administration with G-tubes. A copy of the policy procedure has been posted in medication room. The ADON DON will monitor. Ongoing monitoring for one year. Completed date: 07/08/11 Mandatory in-services were fron June 14 and June 20, 201 for all nursing employees. The in-services addressed policy procedure s for correct handwashing techniques. Nu staff will be monitored for correct with the policy of the policy procedure. | ng n e 23, e held e new s will g n by w g y y and th and n the and l1, nese and ursing | 07/08/2011 |

| l i ' | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|----------------------------|---------------|--|--------------------------------|----------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 15E359 | A. BUII | LDING | 00 | 06/14/2 | |
| | | 15E339 | B. WIN | | | 00/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST IOHN | IS HOME FOR THE | AGED | | 1 | NCOLN AVENUE VILLE, IN47714 | | |
| | | | | | VILLE, IN477 14 | | |
| | | | | | PROVIDER'S PLAN OF CORRECTION | | |
| | · · | | | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | |
| (X4) ID PREFIX TAG | Resident #12 was with the head of approximately 30 12:00 P.M. RN #1 entered the tray of prepared a bedside cabinet. RN #1 was then or resident's bathrood handwashing for RN #1 was then or construction of the construction of | o degrees, on 06/08/11 at the room and set the small medications on the observed to enter the om and perform 10 seconds. observed to apply gloves. observed to remove a 60 a plastic container. The container were observed | | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | for es. vill be ring icing DON | (X5) COMPLETION DATE |
| | resident's abdome | | | | | | |
| | 1351401115 4040111 | | | | | | |
| ı | During an intervi | iew at that time, RN #1 | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MI A. BUII | | NSTRUCTION 00 | (X3) DATE S COMPLI | ETED | |
|--|--|--|--------|---|--|----------|--------------------|
| | | 15E359 | B. WIN | | | 06/14/20 | D11 |
| | PROVIDER OR SUPPLIER | | | 1236 LII | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS' | VILLE, IN47714 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR | | ΓE | (X5) COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | • | DATE |
| | indicated, "Oh, I | heard sounds." | | | | | |
| | residual check w | observed to perform a ithout success. This peated 3 times without tained. | | | | | |
| | indicated, "What Upon query of w normally do, she | ew at that time, RN #1 do you want me to do?" hat RN #1 would indicated, "I would go DoN [Assistant Director | | | | | |
| | gloves, perform l | observed to remove nandwashing for 8 the room, leaving the spervised. | | | | | |
| | RN #1 was then observed to re-enter the room and indicated, "There doesn't always have to be a residual." RN #1 was then observed to enter the bathroom of Resident #13 and perform handwashing for 5 seconds. | | | | | | |
| | | observed to apply gloves o in a 60 cc syringe. | | | | | |
| | the cup, wiped th a Kleenex, and ir | sed the Jevity back into the tip of the syringe with asserted the tip of the 60 the open port of the tube. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M A. BUI | | INSTRUCTION 00 | (X3) DATE S COMPL | ETED | |
|---|--|---|--------|---------------------|--|---------|----------------------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | | • | 1236 LI | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | into the open 60 copious amount of abdomen. During syringe tip was of from the tube, sp the resident's abdoment was then of syringe, attached | observed to hold the to the tube in her left | | | | | |
| | hand, and reach around her body to retrieve needed supplies from the bedside cabinet, applying tension to the tube. | | | | | | |
| | | observed to put the back together and us feeding. | | | | | |
| | MAPAP 20 ml [e via tube without the feeding and be administration. It of fill the open sy tube, with Gatora its cup and fill the water. At that tir syringe disengag Resident #12's ab | RN #1 was then observed vringe, attached to the ade, then pour it back into e open syringe with 30 cc me, the tube and the open ed and water spilled onto odomen. | | | | | |
| | syringe with Gate syringe disengag | observed to fill the open orade and the open ed, with Gatorade ident #12 abdomen. RN | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MI A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE (COMPL 06/14/2 | ETED | |
|---|---|---|--------|----------------|--|----------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIER | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | | | | | NCOLN AVENUE | | |
| ST JOH | NS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | | ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | COMPLETION DATE |
| 1710 | | d, "That has never | | 1710 | · | | DATE |
| | | in all my years of | | | | | |
| | nursing." | w.:, j va.: 01 | | | | | |
| | | | | | | | |
| | RN #1 was then | observed to rinse the | | | | | |
| | syringe with water, remove her gloves and perform handwashing for 10 seconds. | | | | | | |
| | | | | | | | |
| | perform name washing for 10 becomes. | | | | | | |
| | | observed to apply gloves | | | | | |
| | and wipe the syringe with a paper towel. | | | | | | |
| | The syringe was observed, at that time, to | | | | | | |
| | _ | lets on the inner lower | | | | | |
| | | s then observed to return | | | | | |
| | | e plastic container that | | | | | |
| | residue. | still have the tan liquid | | | | | |
| | residue. | | | | | | |
| | RN #1 was then | observed to remove | | | | | |
| | | rm handwashing for 10 | | | | | |
| | | was then observed to | | | | | |
| | apply gloves and | l put supplies away. RN | | | | | |
| | #1 was then obse | erved to remove gloves | | | | | |
| | and perform han | dwashing for 11 seconds. | | | | | |
| | | | | | | | |
| | | with RN #1 at that time, | | | | | |
| | | it she estimated Resident | | | | | |
| | | 1 220 ml of feeding and | | | | | |
| | 60 cc of water ar | ia Galorage | | | | | |
| | In an interview v | with the DoN, on 06/08/11 | | | | | |
| | | e indicated, "The orders | | | | | |
| | • | right there on the MAR, | | | | | |
| | | known what to doWe | | | | | |
| | | n that and handwashing." | | | | | |

000443

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | (X2) MULTIPLE CONSTRUCTION A DULL DING 00 | | | (X3) DATE SURVEY COMPLETED | |
|---|-------------------------------------|------------------------------|---|--------|--|-----------------------------|------------|
| AND TEAN | or conduction | 15E359 | | LDING | | 06/14/2 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , i | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ГЕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENC!) | | DATE |
| | Desires en interni | : | | | | | |
| | ~ | iew with the DoN, on | | | | | |
| | | P.M., she indicated if | | | | | |
| | _ | uestions about g-tubes, | | | | | |
| | 1 - | er and she would look on | | | | | |
| | | DoN indicated the | | | | | |
| | | e had in the facility were | | | | | |
| | from 1980 and 19 | 987. | | | | | |
| | RN #2 was obser | ved administering | | | | | |
| | medications and feeding solution to | | | | | | |
| | | 6/8/11 at 5:50 p.m. She | | | | | |
| | | lol [blood pressure | | | | | |
| | 1 | Ranitidine [medication to | | | | | |
| | I = | acid] together and placed | | | | | |
| | | ation cup with 10 cubic | | | | | |
| | | of water. She had | | | | | |
| | | what she identified as | | | | | |
| | 1 * | tamin D; she obtained a | | | | | |
| | | with a powdery substance | | | | | |
| | _ | outer coating in it. She | | | | | |
| | | ance into a drinking cup | | | | | |
| | l * | cc of water and added it | | | | | |
| | | hen stirred and attempted | | | | | |
| | 1 1 | alcium pill in the water. | | | | | |
| | | ed she needed 10 cc more | | | | | |
| | | the 30 cc water flush | | | | | |
| | _ | nysician. She put about | | | | | |
| | | to a medicine cup. She | | | | | |
| | | 5 cc of Gatorade. She | | | | | |
| | | an of Jevity 1.2 feeding | | | | | |
| | solution. | , . | | | | | |
| | | | | | | | |
| | CNA #2 approac | ched RN #2 and told her | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11 Facility ID:

000443 If continuation sheet Page 26 of 122

| NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED O(A) ID | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MUL A. BUILDI B. WING | | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|--|---|--|--|--|----------------|------------------------------------|------|------|
| ST JOHNS HOME FOR THE AGED (NAJI) D SUMMARY STATEMENT OF DETICINCIES TAG REGILATORY OR ISC IDENTIFYING INFORMATION) REGILATORY OR ISC IDENTIFYING INFORMATION) Resident #12 was complaining of stomach pain. RN #2 indicated she would check on the resident, "maybe it will help if I give this [indicating the medication and feeding]." She indicated the resident might also be complaining of the g-tube site. RN #2 took everything to the resident's room on a plastic tray. She put on gloves and uncovered the resident's abdomen. A gauze dressing was observed around the g-tube at the insertion site. It was soiled with beige solution with some pink tinges. She removed the dressing. With the same gloves, she proceeded to get a syringe out, contained in a plastic container at the bedside. She attached the syringe to the end of the gastrostomy tube and pulled back on the plunger. Nothing entered the syringe chamber. She indicated, "usually don't get anything back, maybe a dribble." She disconnected the syringe and a couple drops of liquid dropped onto kleenex she had placed on the resident's abdomen. "I guess that's all the residual I'm going to get," she stated. She proceeded to take the plunger out of the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from | NAME OF I | PROVIDER OR SUPPLIEI | !! } | | | | | |
| RESIDENT RESIDENCENCY MUST BE PERCUEDED BY FULL REGULATORY OR LOS CIDENTIFYING INFORMATION) RESIDENT RESIDENT BY PERCUEDED BY FULL REGOSS REFERENCED TO THE APPROPRIATE COMPARISON ON DATE RESIDENT RESIDENT BY PERCUEDED BY FULL ROSS REFERENCED TO THE APPROPRIATE COMPARISON OF | ST JOHN | NS HOME FOR THE | E AGED | | | | | |
| Resident #12 was complaining of stomach pain. RN #2 indicated she would check on the resident, "maybe it will help if I give this [indicating the medication and feeding]." She indicated the resident might also be complaining of the g-tube site. RN #2 took everything to the resident's room on a plastic tray. She put on gloves and uncovered the resident's abdomen. A gauze dressing was observed around the g-tube at the insertion site. It was soiled with beige solution with some pink tinges. She removed the dressing. With the same gloves, she proceeded to get a syringe out, contained in a plastic container at the bedside. She attached the syringe to the end of the gastrostomy tube and pulled back on the plunger. Nothing entered the syringe chamber. She indicated, "usually don't get anything back, maybe a dribble." She disconnected the syringe and a couple drops of liquid dropped onto kleenex she had placed on the resident's abdomen. "I guess that's all the residual I'm going to get," she stated. She proceeded to take the plunger out of the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from | | | | | - 1 | | | |
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| entered the syringe chamber. She indicated, "usually don't get anything back, maybe a dribble." She disconnected the syringe and a couple drops of liquid dropped onto kleenex she had placed on the resident's abdomen. "I guess that's all the residual I'm going to get," she stated. She proceeded to take the plunger out of the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from | | container at the syringe to the en | bedside. She attached the d of the gastrostomy tube | | | | | |
| back, maybe a dribble." She disconnected the syringe and a couple drops of liquid dropped onto kleenex she had placed on the resident's abdomen. "I guess that's all the residual I'm going to get," she stated. She proceeded to take the plunger out of the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from | | entered the syrin | ge chamber. She | | | | | |
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| the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from | | the residual I'm | going to get," she stated. | | | | | |
| to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from | | _ | | | | | | |
| that time, she was stopped from | | | | | | | | |
| | | | • | | | | | |
| | | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 00 | | | (X3) DATE S COMPL | | |
|--|---|---------------------------------------|---------|--------|---|---------|------------|
| THETEN | or conduction | 15E359 | A. BUII | | | 06/14/2 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | 1 | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | to assure yourself it [the | | | | | |
| | 1 - | omach?" She indicated, | | | | | |
| | "I guess I didn't.' | | | | | | |
| | | ok off her gloves, exited | | | | | |
| | 1 | turned with a stethoscope. | | | | | |
| | _ | new gloves, injected air | | | | | |
| | _ | omy tube and listened | | | | | |
| | | ope to the abdomen, | | | | | |
| | ı | ard air entering the | | | | | |
| | stomach. | | | | | | |
| | At that time, she disconnected the syringe, | | | | | | |
| | pulled the plunger out and reattached the | | | | | | |
| | 1 ^ ~ | be. She poured the | | | | | |
| | 1 - | the 10 cc of water into | | | | | |
| | | ation was left in the | | | | | |
| | | She opened the can of | | | | | |
| | · · | ed it into the medication | | | | | |
| | | the remaining Calcium | | | | | |
| | | istered via gravity | | | | | |
| | | She then administered | | | | | |
| | _ | dications, in the 10 cc of | | | | | |
| | | Followed by the Gatorade | | | | | |
| | | 15 cc cup of water. | | | | | |
| | | · · · · · · · · · · · · · · · · · · · | | | | | |
| | The policy and p | rocedure for Tube | | | | | |
| | Feeding by Grav | ity/Bolus, dated 7/2005, | | | | | |
| | was provided by | the Director of Nurses on | | | | | |
| | 6/8/11 at 5:15 p.r | The policy and | | | | | |
| | procedure includ | ed, but was not limited | | | | | |
| | to, the following: | | | | | | |
| | "5. Before begin | ning feed always check | | | | | |
| | for correct placer | ment of tube. Insert 30 | | | | | |
| | CC of air from sy | yringe into gastic (sic) | | | | | |

| l | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | | E SURVEY PLETED /2011 |
|--------------------------|--|---|--|--|----------|-----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP C NCOLN AVENUE VILLE, IN47714 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | epigastrium to lise 6. Check for rest Physician's order 7. Attach syring Pour feeding into hold syringe upri until all feeding s by bolus gently p drain the syringe (sic) amount of to given. 8. After feeding per physicians's (The policy and p "Medication-Fee 7/2005, was prov Nurses on 6/9/11 procedure indicate patency by ausculate by attaching the stube and inserting centimeters of air The policy also it be flushed with the after administration. | rocedure for ding Tube," dated rided by the Director of at 1:45 p.m. The ted placement and altation was to be checked syringe to the end of the g twenty cubic r and listening for the air. Indicated the tube was to hirty (30) cc of water on of the medications. | | | | |
| | 2:00 p.m., indica "Medication adm tubes procedures | eviewed on 6/9/11 at ted the following: sinistration via enteral :8. Check for proper 12. Put 15-30 ml | | | | |

000443

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CC | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------|--|--------------------|
| AND PLAIN | OF CORRECTION | 15E359 | A. BUILDING | 00 | 06/14/2011 |
| | | | B. WING | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIER | | | NCOLN AVENUE | |
| | IS HOME FOR THE | | | VILLE, IN47714 | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| | | r in syringe and flush | 1 | | |
| | | vity flow13. Pour | | | |
| | dissolved/diluted | • | | | |
| | syringe14. Flu | sh tubing with 15-30 ml | | | |
| | of water, or prescribed amount" | | | | |
| | | | | | |
| | The Indiana State Board of Nursing | | | | |
| | • | ne Indiana Code and | | | |
| | | trative Code 2009 Edition | | | |
| | indicated, "848 IA member of the nursi | C 2-2-2 Responsibility as a | | | |
| | Authority: IC 25-23- | | | | |
| | Affected: IC 25-23 | ed nurse shall do the following: | | | |
| | | collaborate, and function with | | | |
| | | e health team to provide safe (4) Seek education and | | | |
| | | ssary when implementing | | | |
| | nursing practice tech | | | | |
| | "48 IAC 2-2-3 Unpro Authority: IC 25-23-1 | | | | |
| | Affected: IC 25-23 | aviana (aata kaasuladaa and | | | |
| | practices) failing to | aviors (acts, knowledge, and | | | |
| | | andards of acceptable and | | | |
| | prevailing nursing practice, which could | d jeopardize the health, safety, | | | |
| | and welfare of the | | | | |
| | public, shall constitu These behaviors sha | ite unprofessional conduct. all | | | |
| | | limited to, the following: | | | |
| | (1) Using unsafe jud inappropriate | lgment, technical skills, or | | | |
| | interpersonal behavi | iors in providing nursing care. | | | |
| | (2) Performing any r for which the | nursing technique or procedure | | | |
| | | by education or experience." | | | |
| | 3.1-35(g)(1) | | | | |
| | 5.1 55(B)(1) | | | | |
| | | | | | |
| | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|----------------------------|--|---|
| | | 15E359 | A. BUILDING | 00 | 06/14/2011 |
| | | | B. WING STRE | EET ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 6 LINCOLN AVENUE | |
| | IS HOME FOR THE | | | NSVILLE, IN47714 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DETCENCT) | DATE |
| F0282 SS=D | facility must be proin accordance with plan of care. Based on observative record review, the the written plan of 2 of 3 sampled reincontinence care and for 1 of 1 resigns gastrostomy tubes the sample of 11. Findings include: 1. On 6/7/11 at 8 #4 were observed the bathroom. The 29 to the toilet with the time, both Cowas wet. The britans of the property of the bathroom of the time, both Cowas wet. The britans of the plant of the | 2:45 a.m., CNAs #3 and all to take Resident #29 to hey transferred resident #27th a sit to stand lift. a pull-up type of on. During interview at CNAs indicated the brief hef was removed and the led on the toilet and had a | F0282 | Mandatory in-services were for all nursing employees on 14 and June 20, 2011, address incontinence care and period CNAs will be monitored five weekly providing periodare from the Monitoring will contitude weekly for randomly selected employees. All nevemployees will be in-service periodare during the orientatic process and ongoing in-service will occur bi-annually. The Conurse, ADON, and DON will monitor. Ongoing monitoring one year. Completed 06/22/2 New policy and procedures adopted regarding tube feed and medication administratic with G-tubes. Mandatory in-services were held on Jur June 24, June 27, and will be on July 1, 2011, reviewing the new policies. All nurses and QMAs will have given a return demonstration of tube feeding and medication administration administration and medication administration | a June essing care. times or one nue w ed on ion vicing charge g for v11 were ding on ne 23, e held ne d rn ng |
| | | at was done, the CNAs the lift, wiped her with | | the completion date. Ongoin in-services will occur quarter Nurses and QMAs will be | - 1 |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F359 06/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVENUE ST JOHNS HOME FOR THE AGED EVANSVILLE, IN47714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE observed once daily for one toilet paper, put a clean incontinence month, and then weekly for product on her, dressed her and assisted correct administering of tube her back to the wheelchair. There was no feeding and medication cleansing of the perineal area and thighs administration of G-tubes. The ADON and DON will monitor. following the incontinence of urine. Ongoing monitoring for one year. Completed date: 07/08/11 Resident #29's clinical record was Mandatory in-services were held reviewed on 6/9/11 at 10:00 a.m. on June 14 and June 20, 2011 for all nursing employees addressing policies and procedures for Resident #29's care plan regarding correct handwashing techniques. incontinence, dated 4/14/11, indicated she Nursing staff will be monitored for was to be checked and changed and correct handwashing techniques provided hygiene every 2 hours and as five times weekly for one month. Monitoring will continue twice needed. weekly for randomly selected employees. All new nursing 2. On 6/8/11 at 5:20 p.m., CNAs #1 and employees will be in-serviced on #2 were observed assisting Resident #12 correct handwashing techniques during orientation. Ongoing to the bathroom. The resident was walked in-services will occur bi-annually. to the bathroom with a walker and two The ADON and DON will monitor. assist. A pull-up type of incontinence Ongoing monitoring for one year. brief was removed. It was wet and soiled Completed date: 06/30/11 with a smear of feces. After giving the resident time on the toilet, CNA #2 washed the resident's perineal area by reaching through the legs from the front and, using wash cloths, washing the area from back to front. The CNAs placed a clean incontinence brief on the resident. As the resident stood up, she started to urinate. The staff walked with her back to the bed. They then removed the brief and obtained wet and soapy paper towels from the bathroom

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11

Facility ID:

000443

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIP A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|---|---|---|------------------|---|------|----------------------------|
| NAME OF I | PROVIDER OR SUPPLIEF | " : | | DDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHN | IS HOME FOR THE | AGED | | ICOLN AVENUE /ILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TA | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| | and washed, rins again using the t the bathroom. C cloths, using wh | | | | | |
| | the Director of N p.m., upon interv stated, "of course and got wash clo indicated an inse been done not to | ration was reviewed with furses, on 6/8/11 at 6:50 riew at that time she e they should have gone ths." She further rvice on perineal care had o long ago and the staff to wash back to front. | | | | |
| | Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. The resident had a care plan, dated 5/17/11, for urinary incontinence. The interventions included, but were not limited to, "Staff to assist [Resident's name] with post void hygiene." | | | | | |
| | incontinence, da by the Director of 1:00 p.m. The p | rocedure for care of ted 5/2006, was provided of Nurses on 6/13/11 at olicy indicated, ashed and changed when | | | | |
| | pass, on 06/08/1 indicated she wa medications and | vation of the medication 1 at 12:00 P.M., RN #1 s preparing to administer feeding through a g-tube RN #1 prepared MAPAP | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LWB11 Facility ID:

000443

If continuation sheet Page 33 of 122

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED B. WING | | | |
|--|---|---|---------------------|--|----------------------|
| NAME OF I | PROVIDER OR SUPPLIEF | " { | | T ADDRESS, CITY, STATE, ZIP CODE | • |
| ST JOHN | IS HOME FOR THE | AGED | | LINCOLN AVENUE ISVILLE, IN47714 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | ME OF PROVIDER OR SUPPLIER JOHNS HOME FOR THE AGED DID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ULTIPLE CO LDING | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|--|--|--|---------------------|---------------------|--|---------|----------------------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | | . | 1236 LI | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | RN #1 was then oresidual check who procedure was residual being obsinterview at that "What do you was query of what RN she indicated, "I ADoN ." RN #1 was then orgonized gloves, perform his seconds, and exit medications unsuffered with the seconds and indicated have to be a residual that the seconds. Round to apply gloves a cc syringe. RN #1 to apply gloves a cc syringe with a KN tip of the 60 cc sy of the tube. RN #1 was then orgonized with a KN tip of the 60 cc sy of the tube. RN #1 was then orgonized with a KN tip of the 60 cc sy of the tube. | observed to perform a fithout success. This peated 3 times without stained. During an time, RN #1 indicated, ant me to do?" Upon N #1 would normally do, would go check with the observed to remove nandwashing for 8 the room, leaving the apervised. Observed to re-enter the ed, "There doesn't always dual." RN #1 was then the bathroom of a perform handwashing N#1 was then observed and pull Jevity up in a 60 ft then released the Jevity wiped the tip of the deenex, and inserted the syringe into the open port | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | (X2) MULTIPLE CONSTRUCTION OO | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------------------|---------------|--|----------------------------|------------------|
| 1111212111 | or conditions | 15E359 | A. BUII | | | 06/14/2011 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | E | MPLETION DATE |
| IAG | residents abdome | · · · · · · · · · · · · · · · · · · · | | IAU | | | DATE |
| | residents abdome | JII. | | | | | |
| | RN #1 was obser | ved to hold the syringe, | | | | | |
| | | be in her left hand, and | | | | | |
| | | body to retrieve needed | | | | | |
| | | | | | | | |
| | supplies from the bedside cabinet, applying tension to the tube. | | | | | | |
| | FF 7 6 | | | | | | |
| | RN#1 was then o | observed to put the | | | | | |
| | syringe and tube back together and | | | | | | |
| | complete the bolus feeding. | | | | | | |
| | • | Č | | | | | |
| | RN #1 was then | observed to administer | | | | | |
| | MAPAP 20 ml [e | equals 650 milligrams] | | | | | |
| | via tube without | performing a flush after | | | | | |
| | the feeding and b | pefore medication | | | | | |
| | administration. I | RN #1 was then observed | | | | | |
| | to fill the open sy | ringe attached to the | | | | | |
| | | de the pour it back into | | | | | |
| | | e open syringe with 30 cc | | | | | |
| | _ | ne, the tube and the open | | | | | |
| | | ed and water spilled onto | | | | | |
| | ' ' ' ' ' | odomen. RN #1 was then | | | | | |
| | observed to fill th | ne open syringe with | | | | | |
| | | open syringe disengaged | | | | | |
| | | illing on the Resident | | | | | |
| | #12 abdomen. | | | | | | |
| | | | | | | | |
| | RN #1 was then | observed to rinse the | | | | | |
| | syringe with water | er, remove her gloves and | | | | | |
| | perform handwas | shing for 10 seconds. RN | | | | | |
| | #1 was then obse | erved to apply gloves and | | | | | |
| | wipe the syringe | with a paper towel. The | | | | | |
| | syringe was obse | rved to have water | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MU A. BUIL | | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|---|--|--|---------|---------------------|---|---------|----------------------|
| | | 15E359 | B. WING | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| TAG | droplets on the ir was then observed the plastic contains still have the tan was then observed perform handwas RN #1 was then observed to remote handwashing for interview with R indicated she estimated and Gatora In an interview water and Gatora In an interview wa | anner lower half. RN #1 and to return the syringe to mer that was observed to liquid residue. RN #1 and to remove gloves and shing for 10 seconds. Observed to apply gloves away. RN #1 was then ove gloves and perform 11 seconds. In an N #1, at that time, she imated Resident #12 had of feeding and 60 cc of | | TAG | | | DATE |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|---|--|---|-------------------|----------------|---|---------|--------------------|
| | | 15E359 | A. BUII B. WIN | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSG DENTERVING DISCOMMATIONS | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | (X5) COMPLETION |
| | poured the substate and measured 10 to the cup. She is to dissolve the Cashe then indicate water to make up ordered by the ph 15 cc of water in then poured up 4 also obtained a casolution. CNA #2 approach Resident #12 was pain. RN #2 indo on the resident, "give this [indicate feeding]." She is might also be consite. RN #2 took every room on a plastice and uncovered the gauze dressing we getube at the insee with beige solution. With the same gligget a syringe out, container at the besyringe to the endocrease. | cy MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) ance into a drinking cup ce of water and added it then stirred and attempted alcium pill in the water. and she needed 10 cc more to the 30 cc water flush mysician. She put about to a medicine cup. She see cof Gatorade. She an of Jevity 1.2 feeding the RN #2 and told her as complaining of stomach licated she would check maybe it will help if I mig the medication and adicated the resident mplaining of the g-tube extray. She put on gloves the resident's abdomen. A tras observed around the first on site. It was soiled ton with some pink tinges. dressing. oves, she proceeded to the contained in a plastic to bedside. She attached the did of the gastrostomy tube | | | (EACH CORRECTIVE ACTION SHOULD BE | TE | |
| | and pulled back (| on the plunger. Nothing | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE A. BUILDING B. WING | E CONSTRUCTION 00 | COM | TE SURVEY IPLETED 1/2011 | | | |
|---|--|--|---|---------------------|--------------------------------------|----------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | CROSS-REFERENCED TO | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | | |
| | entered the syring indicated, "usual back, maybe a drathe syringe and a dropped onto klet the resident's about the resident's about the resident's about the syringe and a to the gastrostom medications and that time, she was proceeding and cenough residual tube] is in the storing guess I didn't.' syringe down, to the room, and ret She then put on a into the gastrostom with the stethosc indicating she he stomach. At that time, she pulled the plunger syringe to the tube. At that time, she pulled the plunger syringe to the tube. Medicated medication cup, feeding and pour cup, mixing with tablet and admining the stems of the syringe with the stethosc indication cup. | ge chamber. She ly don't get anything ribble." She disconnected couple drops of liquid enex she had placed on lomen. "I guess that's all going to get," she stated. I take the plunger out of ttach the syringe chamber by tube, to administer the feeding to the tube. At | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDIN | | 00 | COMPL | ETED | |
|---|--|--|-----------------|---------|---|---------|----------------------------|
| | | 15E359 | B. WING | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | AGED | 12 | 236 LIN | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE /ILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | II PRE TA | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| | fluid. That was f and then the last Resident #12's cl reviewed on 6/7/ a care plan, dated tube. The interve were not limited "-Maintain [Residube for feeding/n-check residual, p to feed/med pass. [water] and 45 cd after each feeding | 11 at 10:10 a.m. She had 15/17/11, for her gastric entions included, but to, the following: dent's name] gastrostomy medicating purposes. cositioning of tube prior Give 30 cc of H2O of sports drink via tube g and med pass. Check sounds prior to and | | | | | |
| F0312 SS=D | of daily living recei | unable to carry out activities ves the necessary services utrition, grooming, and hygiene. | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|--|--------------------------------------|--------------------------------|---------|------------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DINC | 00 | COMPI | ETED |
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | | <u> </u> | B. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | NCOLN AVENUE | | |
| ST JOH | NS HOME FOR THE | E AGED | | | VILLE, IN47714 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΤE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | | ration, interview and | F0 | 312 | Mandatory in-services were | | 06/30/2011 |
| | record review, the | ne facility failed to ensure | | | for all nursing employees on 14 and June 20, 2011 addre | | |
| | 2 of 3 sampled r | esidents observed during | | | peri and incontinence care | SSILIG | |
| | incontinence car | e, in the sample of 11, | | | procedures. CNAs will be | | |
| | received appropr | riate personal hygiene, in | | | monitored providing peri-car | | |
| | 1 | the perineal area was not | | | times a week for one month. | | |
| | | s not thorough or | | | Monitoring will continue twic | | |
| | 1 | esidents #12, #29) | | | weekly for randomly selected employees. All new employees. | | |
| | appropriate. (11) | | | | will be in-serviced on peri- c | | |
| | Findings include | <u>.</u> | | | during the orientation proces | | |
| | 1 manigs merade | | | | and ongoing bi-annual | | |
| | 1 0 (/7/11 -4 | 0.45 CNIA - //2 1 | | | in-servicing addressing peri- | | |
| | | 8:45 a.m., CNAs #3 and | | | will occur. The charge nurse | | |
| | | d to take Resident #29 to | | | ADON and DON will monitor Ongoing monitoring for one | | |
| | 1 | They transferred her to the | | | | усаг. | |
| | toilet with a sit t | o stand lift. The resident | | | | | |
| | had a pull-up typ | pe incontinence brief on. | | | | | |
| | During interview | v at that time both CNAs | | | | | |
| | indicated the bri | ef was wet. The brief was | | | | | |
| | removed, the res | sident was seated on the | | | | | |
| | toilet and had a | bowel movement while | | | | | |
| | there. | | | | | | |
| | | | | | | | |
| | When the reside | nt was done, the CNAs | | | | | |
| | | h the lift, wiped her with | | | | | |
| | 1 | • | | | | | |
| | | a clean incontinence | | | | | |
| | 1 ~ | dressed her and assisted | | | | | |
| | | wheelchair. There was no | | | | | |
| | | perineal area and thighs | | | | | |
| | following the incontinence of urine. | | | | | | |
| | Resident #29's clinical record was | | | | | | |
| | reviewed on 6/9/11 at 10:00 a.m. | | | | | | |
| | | are plan regarding | | | | | |
| | 1 | ted 4/14/11, indicated she | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | ONSTRUCTION 00 | l' ' | TE SURVEY MPLETED | |
|---|--|------------------------------|------------------------|---|----------------------|------------|
| | | 15E359 | A. BUILDING B. WING | | | 4/2011 |
| | PROVIDER OR SUPPLIER | | STREET A 1236 L | ADDRESS, CITY, STATE, ZIP INCOLN AVENUE SVILLE, IN47714 | CODE | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | 1 | | (X5) |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | PREFIX | PROVIDER'S PLAN OF C | N SHOULD BE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO TH DEFICIENCY) | HE APPROPRIATE) | DATE |
| | was to be checke | ed and changed and | | | | |
| | provided hygien | e every 2 hours and as | | | | |
| | needed. | | | | | |
| | | | | | | |
| | 2. On 6/8/11 at | 5:20 p.m., CNAs #1 and | | | | |
| | | d assisting Resident #12 | | | | |
| | 1 | The resident was walked | | | | |
| | 1 | with a walker and two | | | | |
| | 1 ^ ^ | type of incontinence | | | | |
| | brief was removed. It was wet and soiled | | | | | |
| | with a smear of | feces. | | | | |
| | After giving the resident time on the | | | | | |
| | | vashed the resident's | | | | |
| | 1 | reaching through the legs | | | | |
| | 1 - | nd, using wash cloths, | | | | |
| | | from back to front. The | | | | |
| | 1 - | clean incontinence brief | | | | |
| | 1 * | As the resident stood up, | | | | |
| | 1 | nate. The staff walked | | | | |
| | 1 | the bed. They then | | | | |
| | 1 | ef and obtained wet and | | | | |
| | | els from the bathroom | | | | |
| | | sed, and dried the resident | | | | |
| | 1 | prown paper towels from | | | | |
| | 1 - | Ouring interview at that | | | | |
| | time, CNA #1 st | ated, "No wash cloths, | | | | |
| | using what I hav | e." | | | | |
| | When the observ | vation was reviewed with | | | | |
| | 1 | Surses, on 6/8/11 at 6:50 | | | | |
| | | view at that time she | | | | |
| | | e they should have gone | | | | |
| | · · | oths." She further | | | | |
| | Tana got wash cic | ouis. She fulther | - 1 | 1 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | ľ | E SURVEY PLETED /2011 | |
|---|---|--|---------------------|--|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP CO NCOLN AVENUE VILLE, IN47714 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | been done not to | ervice on perineal care had o long ago and the staff to wash back to front. | | | | |
| | reviewed on 6/7/resident had a caurinary incontine included, but we assist [Resident's hygiene." 3. The policy an incontinence, day by the Director of 1:00 p.m. The p | linical record was 711 at 10:10 a.m. The re plan, dated 5/17/11, for ence. The interventions re not limited to, "Staff to a name] with post void and procedure for care of ted 5/2006, was provided of Nurses on 6/13/11 at olicy indicated, rashed and changed when | | | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F359 06/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVENUE ST JOHNS HOME FOR THE AGED EVANSVILLE, IN47714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0322 Based on the comprehensive assessment of a resident, the facility must ensure that a SS=D resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. F0322 New policy and procedures were 07/08/2011 Based on observation, interview and adopted regarding tube feeding record review, the facility failed to ensure and medication administration 1 of 1 resident with a gastrostomy tube, in with G-tubes. Mandatory the sample of 11, was provided in-services were held on June 23. June 24, June 27, and will be held appropriate treatment and services to on July 1, 2011, reviewing the prevent potential complications, in that new policies. All nurses and placement was not checked prior to QMAs will have given a return administration of feedings and/or demonstration of tube feeding medications, flushes were not adequate, and medication administration by the completion date. Ongoing and infection control practices were in-services will occur quarterly. deficient. (Resident #12) Nurses and QMAs will be observed once daily for one month, and then weekly for Findings include: correct administering of tube feeding and medication During an observation of the medication administration of G-tubes. The pass, on 06/08/11 at 12:00 P.M., upon ADON and DON will monitor. interview at that time, RN #1 indicated Ongoing monitoring for one year. Completed date: 07/08/11 she was preparing to administer Mandatory in-services were held medications and feeding through a g-tube. on June 14 and June 20, 2011 for RN #1 prepared MAPAP (Tylenol) 20 ml all nursing employees addressing [milliliters] (650 mg) and placed in a policies and procedures for correct handwashing techniques. medication cup. RN #1 obtained 240 ml Nursing staff will be monitored for of Jevity (liquid nutrition), 45 cc [cubic correct handwashing techniques centimeters] of Gatorade, and 30 cc of five times weekly for one month. water and placed them on a small tray for Monitoring will continue twice weekly for randomly selected transport to resident's room. employees. All new nursing

If continuation sheet

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|--|-----------------------|------------------------------|--------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | , DITT | LDDIC | 00 | COMPL | ETED |
| | | 15E359 | - 1 | LDING | | 06/14/2 | 011 |
| | | | B. WIN | | DDDEGG CUTY CTATE TIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 3 | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 1 | NCOLN AVENUE | | |
| STJOHN | IS HOME FOR THE | = AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | _ | DATE |
| | | | İ | | employees will be in-service | d on | |
| | Resident #12 wa | s observed lying in bed, | | | correct handwashing technic | ues | |
| with the head of bed elevated | | | | | during orientation. Ongoing | | |
| | | | | | in-services will occur bi-annu | | |
| | | 0 degrees, on 06/08/11 at | | | The ADON and DON will mo | | |
| | 12:00 P.M. | | | | Ongoing monitoring for one | /ear. | |
| | | | | | Completed date: 06/30/11 | hold | |
| | RN #1 entered re | oom and set the small tray | | | Mandatory in-services were on June 20, June 23, June 2 | | |
| | | ications on the bedside | | | and will be held on July 1, 20 | | |
| | | was then observed to enter | | | regarding correct glove usag | | |
| | | throom and perform | | | with procedures. Proper glov | | |
| | | • | | | usage will be monitored five | | |
| | | 10 seconds. RN#1 was | | | a week for one month. | | |
| | | apply gloves. RN#1 was | | | Monitoring will continue twice | | |
| | then observed to | remove a 60 cc syringe | | | weekly for randomly selected | t | |
| | from a plastic co | ontainer. The syringe and | | | employees. All new nursing | | |
| | the container wa | s observed to have a tan | | | employees will be in-service | d on | |
| | | n an interview at that | | | proper glove usage during | iooo | |
| | 1 - | icated, "That is from the | | | orientation. Ongoing in-serv will be held bi-annually. The | ices | |
| | i - | | | | ADON and DON will monitor | | |
| | previous feeding | r,'' | | | Ongoing monitoring for one | | |
| | | | | | Completed date: 07/08/11 | , | |
| | RN #1 was then | observed to install a 30 | | | | | |
| | cc air bolus to th | e open port of the g-tube. | | | | | |
| | | observed to remove the | | | | | |
| | | n around her neck and | | | | | |
| | 1 | the stethoscope to the | | | | | |
| | | - | | | | | |
| | | nen. RN#1 indicated, | | | | | |
| | "Oh, I heard sou | nas." | | | | | |
| | | | | | | | |
| | RN #1 was then | observed to perform a | | | | | |
| | residual check w | vithout success. This | | | | | |
| | procedure was re | epeated 3 times without | | | | | |
| | 1 ~ | btained. During an | | | | | |
| | I - | - | | | | | |
| | | time, RN #1 indicated, | | | | | |
| | 1 | ant me to do?" Upon | | | | | |
| | I query of what R | N #1 would normally do | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE C | ONSTRUCTION 00 | COM | TE SURVEY IPLETED 1/2011 | |
|--|--|---|---------------------|--|----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 L | ADDRESS, CITY, STATE, ZIP C INCOLN AVENUE SVILLE, IN47714 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | she indicated, "I ADoN ." | would go check with the | | | | |
| | gloves, perform l | observed to remove nandwashing for 8 the room, leaving the apervised. | | | | |
| | room and indicat have to be a resid observed to enter Resident #12 and for 5 seconds. R to apply gloves a cc syringe. RN # back into the cup syringe with a KI | observed to re-enter the ed, "There doesn't always dual." RN #1 was then the bathroom of I perform handwashing N#1 was then observed and pull Jevity up in a 60 f1 then released the Jevity wiped the tip of the leenex, and inserted the yringe into the open port | | | | |
| | into the open 60 copious amount of abdomen. During syringe tip was o | observed to pour Jevity acc syringe, spilling a conto the residents at the bolus feeding, the beserved to disengage illing Jevity onto the con. | | | | |
| | attached to the tu reach around her | ved to hold the syringe, be in her left hand, and body to retrieve needed bedside cabinet, to the tube. | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUILDING | E CONSTRUCTION 00 | COM | TE SURVEY MPLETED 4/2011 | | | |
|---|----------------------|--|---|---|--------------------------|--------------------|--|--|
| | PROVIDER OR SUPPLIER | | B. WING OU/14/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) | | |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY | THE APPROPRIATE | COMPLETION DATE | | |
| | | observed to put the back together and us feeding. | | | | | | |
| | MAPAP 20 ml [e | observed to administer equals 650 milligrams] performing a flush after | | | | | | |
| | ~ | perfore medication RN #1 was then observed | | | | | | |
| | | ringe attached to the de the pour it back into | | | | | | |
| | its cup and fill th | e open syringe with 30 cc | | | | | | |
| | | ne, the tube and the open ed and water spilled onto | | | | | | |
| | | odomen. RN #1 was then ne open syringe with | | | | | | |
| | Gatorade and the | open syringe disengaged | | | | | | |
| | _ | illing on the Resident N #1 then indicated, | | | | | | |
| | | nappened to me in all my | | | | | | |
| | | observed to rinse the | | | | | | |
| | ' " | er, remove her gloves and shing for 10 seconds. RN | | | | | | |
| | | erved to apply gloves and | | | | | | |
| | | with a paper towel. The rved to have water | | | | | | |
| | droplets on the ir | nner lower half. RN #1 | | | | | | |
| | | ed to return the syringe to | | | | | | |
| | | ner that was observed to liquid residue. RN #1 | | | | | | |
| | | ed to remove gloves and | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | | (X2) MUI A. BUILI B. WING | DING | nstruction 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|--|--|--|---------------|---------------|--|----------|------------|
| NAME OF A | | <u> </u> | p: \\ \\ \\ \ | | DDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEI | (| | 1236 LI | NCOLN AVENUE | | |
| ST JOHN | NS HOME FOR THE | E AGED | | EVANS\ | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | P | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION |
| TAG | + | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENC!) | | DATE |
| | perioriii nandwa | sning for to seconds. | | | | | |
| | RN #1 was then and put supplies observed to remain handwashing for interview with R indicated she est received 220 ml water and Gators. In an interview wat 4:30 P.M., she for the tube are in she should have just inserviced on RN #2 was obseined in the should have just inserviced on RN #2 was obseined in the should have just inserviced on RN #2 was obseined in the should have just inserviced on RN #2 was obseined in the should have just inserviced on RN #2 was obseined in the should have just inserviced on the should have just inservic | with the DoN, on 06/08/11 e indicated, "The orders right there on the MAR, known what to doWe n that and handwashing." rved administering feeding solution to 6/8/11 at 5:50 p.m. She blol [blood pressure Ranitidine [medication to acid] together and placed ation cup with 10 cubic of water. She had what she identified as tamin D; she obtained a with a powdery substance outer coating in it. She ance into a drinking cup 0 cc of water and added it then stirred and attempted | | | | | |
| | | Calcium pill in the water. | | | | | |
| | | ed she needed 10 cc more | | | | | |
| | water to make u | p the 30 cc water flush | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 06/14/2011 | | |
|---|---|---|---|---------------------|---|-------|----------------------------|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | NTE . | (X5) COMPLETION DATE |
| TAG | ordered by the pl 15 cc of water in then poured up 4 also obtained a cr solution. CNA #2 approace Resident #12 was pain. RN #2 ind on the resident, " give this [indicat feeding]." She in might also be con site. RN #2 took every room on a plastic and uncovered the gauze dressing w g-tube at the inse with beige solution She removed the With the same gl get a syringe out container at the be syringe to the end and pulled back of entered the syring indicated, "usual back, maybe a dr | oves, she proceeded to contained in a plastic redside. She attached the d of the gastrostomy tube on the plunger. Nothing ge chamber. She ly don't get anything libble." She disconnected | | TAG | DEFICIENCY) | NIE | DATE |
| | dropped onto kle | couple drops of liquid enex she had placed on omen. "I guess that's all | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11

Facility ID:

000443

If continuation sheet

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|--|--|--|--------|----------------|--|------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIER | <u>"</u> } | _ | | DDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHN | IS HOME FOR THE | E AGED | | | NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | \top | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | rE | COMPLETION DATE |
| | | going to get," she stated. | | | | | |
| | She proceeded to take the plunger out of | | | | | | |
| | | attach the syringe chamber | | | | | |
| | · - | ny tube, to administer the | | | | | |
| | | feeding to the tube. At | | | | | |
| | that time, she wa | gueried, "Did you get | | | | | |
| | ı ^ | to assure yourself it [the | | | | | |
| | _ | omach?" She indicated, | | | | | |
| | "I guess I didn't. | " At that time, she put the | | | | | |
| | syringe down, to | ook off her gloves, exited | | | | | |
| | | turned with a stethoscope. | | | | | |
| | 1 ^ | new gloves, injected air | | | | | |
| | _ | omy tube and listened | | | | | |
| | | cope to the abdomen, eard air entering the | | | | | |
| | stomach. | ard an entering the | | | | | |
| | | | | | | | |
| | At that time, she | disconnected the syringe, | | | | | |
| | ^ | er out and reattached the | | | | | |
| | | be. She poured the | | | | | |
| | | the 10 cc of water into | | | | | |
| | | ation was left in the She opened the can of | | | | | |
| | 1 ^ | red it into the medication | | | | | |
| | | the remaining Calcium | | | | | |
| | | istered via gravity | | | | | |
| | | . She then administered | | | | | |
| | the other two me | edications, in the 10 cc of | | | | | |
| | | followed by the Gatorade | | | | | |
| | and then the last | 15 cc cup of water. | | | | | |
| | Resident #12's c | linical record was | | | | | |
| | reviewed on 6/7/ | /11 at 10:10 a.m. She had | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LWB11 Facility ID:

000443

If continuation sheet Page 50 of 122

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUILDIN | | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|--|-----------------------------------|--|---------|----------------|--|---------|--------------------|
| | | 10000 | B. WING | TDEET A | DDRESS, CITY, STATE, ZIP CODE | 00/14/2 | V 1 I |
| NAME OF I | PROVIDER OR SUPPLIER | | | | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | | I | | /ILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | II | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | EFIX AG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| | | d 5/17/11, for her gastric | | 10 | | | 5.112 |
| | _ | entions included, but | | | | | |
| | | to, the following: | | | | | |
| | | dent's name] gastrostomy | | | | | |
| | I = | medicating purposes. | | | | | |
| | | positioning of tube prior | | | | | |
| | | . Give 30 cc of H2O | | | | | |
| | 1 | of sports drink via tube | | | | | |
| | | g and med pass. Check | | | | | |
| | [Resident's] lung | sounds prior to and | | | | | |
| | following each feeding." | | | | | | |
| | | | | | | | |
| | The policy and procedure for Tube | | | | | | |
| | Feeding by Grav | ity/Bolus, dated 7/2005, | | | | | |
| | was provided by | the Director of Nurses on | | | | | |
| | 6/8/11 at 5:15 p.1 | The policy and | | | | | |
| | procedure includ | ed, but was not limited | | | | | |
| | to, the following | : | | | | | |
| | | ning feed always check | | | | | |
| | 1 ^ | ment of tube. Insert 30 | | | | | |
| | | yringe into gastic (sic) | | | | | |
| | | ng stethoscope over | | | | | |
| | | sten for influx of air. | | | | | |
| | | idual feeding. See | | | | | |
| | l - | rs for instructions. | | | | | |
| | - | e to end of gastric tube. | | | | | |
| | | syringe, if by gravity, | | | | | |
| | | ght to facilitate draining | | | | | |
| | | solution is completed. If | | | | | |
| | ' ' ' | oush plunger down to | | | | | |
| | 1 | of feeding until currect | | | | | |
| | , , | ube feeding has been | | | | | |
| | given. | 1 . 9 | | | | | |
| | 8. After feeding | is complete, flush tube | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING O | | | (X3) DATE SURVEY COMPLETED | |
|---|---|------------------------------|--|--------|---|-------------------------------|------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| NAME OF F | PROVIDER OR SUPPLIER | | _ | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 1 | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` · | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| IAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | per physicians's (| (SIC) orders. | | | | | |
| | The meliev and m | ma a a drima fam | | | | | |
| | The policy and procedure for "Medication-Feeding Tube," dated | | | | | | |
| | | vided by the Director of | | | | | |
| | | at 1:45 p.m. The | | | | | |
| | | ted placement and | | | | | |
| | - | iltation was to be checked | | | | | |
| | | syringe to the end of the | | | | | |
| | | | | | | | |
| | tube and inserting twenty cubic centimeters of air and listening for the air. | | | | | | |
| | | ndicated the tube was to | | | | | |
| | | hirty (30) cc of water | | | | | |
| | | ion of the medications. | | | | | |
| | arter administrati | ion of the medications. | | | | | |
| | A policy and pro | cedure for Handwashing, | | | | | |
| | dated 05/2006, p | rovided by the DoN on | | | | | |
| | 06/08/11 at 5:15 | P.M., indicated, "Policy | | | | | |
| | All staff providing | ng direct patient care or | | | | | |
| | having any physi | cal contact with resident | | | | | |
| | or their equipmen | nt shall wash their hands | | | | | |
| | frequently. This | will include, but is not | | | | | |
| | limited to: 2. Be | etween contact with | | | | | |
| | different Residen | ıt | | | | | |
| | 3. Before and af | ter any physical contact | | | | | |
| | with Resident eq | uipment or personal | | | | | |
| | | and after any procedure | | | | | |
| | with Resident7 | . After the removal of | | | | | |
| | gloves Procedu | re2. lather hands and | | | | | |
| | rub vigorously fo | or ten to fifteen (10-15) | | | | | |
| | seconds." | | | | | | |
| | | | | | | | |
| | | edication Handbook, | | | | | |
| | Eighth Edition, re | eviewed on 6/9/11 at | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 06/14/2011 | |
|--|--|---|---------------------|---|-----------------------------|
| | PROVIDER OR SUPPLIER | | STREET A 1236 LI | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | "Medication adm tubes procedures tube placement [milliliters] wate tubing using grav dissolved/diluted | sh tubing with 15-30 ml | | | |
| F0323 SS=K | environment rema hazards as is poss receives adequate devices to prevent A. Based on obs record review, th side rails were sa the slats exceede potential for entr | nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. ervation, interview and e facility failed to ensure ife, in that gaps between d 4 and 3/4 inches, with apment of head/neck or to ensure residents were | F0323 | When the facility was notifie the deficient practice, all sid were immediately assessed measured. Side rails that exceeded 4 and ¾ inches w covered. All bottom side rail were removed. Starting on . | e rails and ere Is |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11

Facility ID:

000443

If continuation sheet

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | LTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|---|--|------------------------------|---------|-----------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | ETED |
| | | 15E359 | B. WINC | | | 06/14/2 | 011 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1236 LII | NCOLN AVENUE | | |
| | IS HOME FOR THE | | | | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΤE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | • | | DATE |
| | 1 ^ | sion and assistive devices | | | 9, 2011, the side rail covers was monitored every shift to ensure. | | |
| | 1 - | with potential for serious | | | the covers and tape were se | | |
| | injury, in that interventions were not | | | | Also on this date, the side ra | | |
| | | and new interventions | | | were ordered. Monitoring | | |
| | were not attempt | ed when interventions | | | continued every shift until all | | |
| | were unsuccessfu | al. This deficient practice | | | side rail kits were received a installed. All side rail kits ha | | |
| | affected 8 of 11 s | sampled residents with | | | been installed. If new beds a | | |
| | falls and/or side | rail gaps, and 19 of 19 | | | received in the facility, the | ··· • | |
| | supplemental sar | nple residents with side | | | maintenance department will | I | |
| | rail gaps, in the s | supplemental sample of | | | examine each bed's side rail | | |
| 29. (Residents #15, #41, #10, #12, #23, | | | | | compliance. Compliance wil | | |
| | · · | 22, #16, #42, #6, #19, | | | monitored by the maintenant department. Completed 06/2 | | |
| | | 3, #31, #7, #40, #2, #35, | | | Mandatory in-services were | | |
| | #1, #37, #11, #9, | | | | on June 23, June 24, June 2 | | |
| | $\begin{bmatrix} \pi_1, \pi_2/, \pi_{11}, \pi_2, \\ \end{bmatrix}$ | #26) | | | and will be held on July 1, 20 | | |
| | This deficient and | | | | addressing proper storage of | | |
| | This deficient pra | | | | chemicals. Chemicals were | | |
| | 1 | rdy. The Immediate | | | removed and placed in a lock cabinet. All chemicals will be | | |
| | 1 | on 6/7/11. The Facility | | | under lock and key when not | | |
| | | resident of the facility, | | | use. Soiled utility rooms will | | |
| | | of Nurses [DoN] were | | | monitored every shift for unlo | ocked | |
| | notified of the In | nmediate Jeopardy on | | | or unattended chemicals. Th | | |
| | 6/7/11. The Imm | nediate Jeopardy was | | | charge nurse, ADON, and De | | |
| | removed on 6/11 | /11, but the facility | | | will monitor. Ongoing monito for one year. Completed dat | ~ | |
| | remained out of | compliance at the level of | | | 07/02/11 Medication in-service | | |
| | pattern no actual | harm with the potential | | | will be held on July 7 and Jul | | |
| | _ | nimal harm, because the | | | 2011, for nurses and QMAs | - ' | |
| | | ed to obtain permanent | | | addressing medications left | | |
| | I | ll the gaps, monitor to | | | unattended and outside the | | |
| | | rary fix remained intact | | | of the nurse. Nurses and QN will be monitored five times a | | |
| | _ | ent side rail kits arrived, | | | week for one month. Monito | | |
| | _ | tor interventions to | | | will continue twice weekly for | - | |
| | | | | | compliance. New hires will b | ре | |
| | l ^ | their effectiveness and | | | in-serviced regarding this iss | | |
| | revise intervention | ons as necessary. | | | during the orientation proces | | |
| | | | | | and ongoing in-services will | pe | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-------------------------------|--|---|
| | | 15E359 | A. BUILDING B. WING | 00 | 06/14/2011 |
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP CODE INCOLN AVENUE SVILLE, IN47714 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE |
| | record review, the the environment hazards, for 30 of as cognitively imwere unlocked and medications were medication cart of outside of the view physical therapy | e left on top of the luring medication passes, ew of the nurse, and the room was left unlocked with a hydroculator r. | | held bi-annually. The consult pharmacist will provide med reviews monthly for three monthly for three monthly for three monthly for the ADC and DON will monitor. Ongoin monitoring for one year. Completed date: 07/14/11 Mandatory in-services will be on July 5, July 6, July 7, and 8, 2011, for all nursing emploregarding accidents and haz—specifically leaving the phytherapy (PT) room unlocked unattended. During the survigin was placed on the door the PT room that states, "Phytherapy room must be locked staff is not in attendance". The hydroculator has been move a secure and locked room with the physical therapy room. In key to the room is secure and freach of residents. A sign also been placed on the doo where the hydroculator is locked at all times if staff is not attendance". Mandatory in-services will be held on July 6, July 7, and July 8, 20 for all nursing employees addressing the physical thera room being unlocked and unattended with a hydroculator holding hot water inside. The charge nurse, ADC and DON will monitor. Ongoin monitoring for one year. Completed date: 07/14/11 Mandatory in-services will be on July 5, July 6, July 7, and 8, 2011, for all nursing | pass with DN ng held July byees ards sical and ey, a of ysical d if ne d to thin he d out has f ated e ot in ly 5, 11, apy er DON, ng |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 06/14/2011 | |
|---|---------------------|---|---------------------|--|--|
| | ROVIDER OR SUPPLIER | | STREET | ADDRESS, CITY, STATE, ZIP CODE INCOLN AVENUE SVILLE, IN47714 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | employees. The in-services address tab and pad alarms correct usage. Residents walarms in place will be checked each shift for correct placen of alarm and alarm box. Ala assessments will be completed quarterly and as needed. The charge nurse, ADON and Dwill monitor. Ongoing monitors one year. Completed da 07/11/11 New side rail assessments were complete all residents. A list of reside using side rails were placed CNA's charting book and the treatment book for references Side rail assessments will be completed on a quarterly be with change of condition, are care plan will be updated to reflect any change. This will monitored weekly with the completed on July 7 and July 7. In addressing medication administration. The facility and procedure for medication administration. The facility and procedure for medication administration of medication administration of medication one month. Monitoring will continue twice weekly after first month. New hires will be in-serviced during orientation ongoing in-servicing will occupies and updated to consultant pharmacist will perform | sith ked hent rm eted he ON bring hte: ed on ents in the e e. e esis, or hd the II be are will g for ces uly 8, n policy on viced. In for the he h |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11 Facility ID:

000443

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S COMPL | | |
|--|--|---|------------|--------------|--|-----------|--------------------|
| AND PLAN | OF CORRECTION | 15E359 | A. BUI | LDING | 00 | 06/14/2 | |
| | | 10000 | B. WIN | | | 00/14/2 | 011 |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| | | TATEMENT OF DEFICIENCIES | | | · · · · · · · · · · · · · · · · · · · | | (7/5) |
| (X4) ID PREFIX | | CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | * | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | DATE |
| TAG | A1. Resident #30 reviewed on 6/7/resident's diagnor not limited to, Padementia, osteopy spinal stenosis, of pulmonary disease. The resident's moderated 4/21/11, increquired extensive transfers and ambifalls since the lass resident's most reassessment was dindicated the resident's most reassessment, date resident expresses side rails raised from and/or comfort, how of consciousness had visual deficit of bed safely, had the side rails for phad not attempted rails, had evidence a desire or reason | 0's clinical record was 11 at 12:07 p.m. The ses included, but were arkinson's disease, enia, osteoarthritis, hronic obstructive se, and hypertension. ost recent quarterly set [MDS] assessment, dicated the resident re assistance of 1 for bulation, and had not had at assessment. The exent Fall Risk stated 4/20/11 and dent was at high risk for | | TAG | medication administration revenonthly for three months and then quarterly. The ADON ar DON will monitor. Ongoing monitoring for one year. Completed date: 07/14/11 | view d | DATE |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE COMPI 06/14/2 | LETED | |
|--|--|---|---------------------|--|-------|----------------------|
| | PROVIDER OR SUPPLIEF | | 1236 L | ADDRESS, CITY, STATE, ZIP CODI INCOLN AVENUE SVILLE, IN47714 | 3 | |
| | | | | · · · · · · · · · · · · · · · · · · · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | that would requi antidepressant an | re safety precautions, an and diuretic. | | | | |
| | potential, dated a resident's last do 01/15/11. Interv following: "-May use mech when [resident] : Encourage [resident] task as able. Pad chair and wheelchair for lo allow [resident] task as able. Pad chair and wheelchair sto ambutant encourage [resident] task as able. Pad chair and wheelchair for lotal attempts to ambutant encourage [resident] task as able. Pad chair and wheelchair and wheelchair footweath. Ensure [resident] task as able. Pad chair and wheelchair footweath. Ensure [resident] task as able. Pad chair and wheelchair footweath. Ensure [resident] task as able. Pad chair and the footweath. Ensure [resident] task as able. Pad chair and that frequent easy reach. Ensure one side against the wall. | nt] with gait belt and she is able/willing to bear abs per MD orders. t's] area is free of clutter tly used articles are within of [resident's] bed is up | | | | |
| | sitting upright or | m. "Resident observed n floor/closet/in room. nint of] discomfort. | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ULTIPLE CO LDING | nstruction 00 | COMPI | | |
|---|---------------------------------------|--|---------------------|------------------|--|---------|--------------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | Ţ | |
| | | | | 1 | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | COMPLETION DATE |
| IAG | | ange of motion] all | | IAG | BEITELENETY | | DATE |
| | I = | out] difficulty. Assist of | | | | | |
| | - | to standing position. | | | | | |
| | ' ' | i [one] assist, rolling | | | | | |
| | _ | athroom [without] c/o | | | | | |
| | | rt. Alarm observed on | | | | | |
| | 1 ^ | Assisted resident back to | | | | | |
| | | ace. Reminded to use | | | | | |
| | call light prn [as | | | | | | |
| | • • | n. "B/P [blood pressure] | | | | | |
| | 128/64 T [tempe | rature] 97.1 P [pulse] 88 | | | | | |
| | R [respirations] 2 | 20 O2 [oxygen] sat | | | | | |
| | [saturation] 95% | on RA [room air]. | | | | | |
| | Denies discomfo | rt." | | | | | |
| | 1/12/11 1:15 a.m | . "Heard noise in hallway | | | | | |
| | near resident's ro | om. Staff to area. | | | | | |
| | Resident observe | ed in hallway outside of | | | | | |
| | 1 | in her wheelchair. | | | | | |
| | | eside wheelchair. | | | | | |
| | | nt's night gown to be on | | | | | |
| | · · · · · · · · · · · · · · · · · · · | re strings tied. Alarm | | | | | |
| | observed on bed | | | | | | |
| | | to/from bathroom, skin | | | | | |
| | | ripper socks [changed], | | | | | |
| | | sted back to bed. alarm | | | | | |
| | | ain reminded resident to | | | | | |
| | _ | ace and to use call light | | | | | |
| | PRN assist" | . HIT and the sens the first of the sens | | | | | |
| | | . "Had been in bed about | | | | | |
| | floor beside her | she was found on the | | | | | |
| | | | | | | | |
| | _ | m. "Had been returned to | | | | | |
| | | larm on as before. Now | | | | | |
| | Tourid on moor ag | gain. Had pulled blanket | | | | | |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | COMPL | | |
|---|----------------------|--|--------|---------------|---|----------|--------------------|
| | | 15E359 | | LDING | | 06/14/2 | |
| | | | B. WIN | | DDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1 | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE. | COMPLETION DATE |
| IAG | up straight on be | | | IAG | | | DAIL |
| | | s magnet was clipped to | | | | | |
| | itself so that it w | | | | | | |
| | | n. "Resident [up] in | | | | | |
| | | n Holy Family Unit as to | | | | | |
| | | ıl eyes. Tab alarm on (L) | | | | | |
| | | al clipped to gown. | | | | | |
| | | pped to (R) [right] side | | | | | |
| | | she is @ this time | | | | | |
| | unaware of 2nd t | ab alarm." | | | | | |
| | 4/25/11 3-11 p.m | ı. "Weekly | | | | | |
| | SummaryTook | tabs alarm off once | | | | | |
| | without it soundi | ng and sat on side of bed | | | | | |
| | and was seen and | l toileted per staff" | | | | | |
| | 6/4/11 7:15 p.m. | "Resident now in | | | | | |
| | recliner. Has sou | unded alarm X 4 getting | | | | | |
| | | things independently. | | | | | |
| | Are monitoring of | elosely." | | | | | |
| l | On 6/8/11 at 9:20 | a.m., Resident #30 was | | | | | |
| | observed to be se | eated in her recliner chair | | | | | |
| | | he tabs type alarm box | | | | | |
| | was located on the | ne arm of the chair to the | | | | | |
| | right of the reside | ent. The string was | | | | | |
| | | sident's right shoulder. | | | | | |
| | | as not attached to | | | | | |
| | | lize it if the resident | | | | | |
| | attempted to get | up. | | | | | |
| | Resident #30's si | de rails were measured, | | | | | |
| | on 6/7/11 at 9:45 | a.m. and gaps between | | | | | |
| | | ed up to 7 and 3/8 inches. | | | | | |
| | A2. On 6/7/11 a | t 9:30 a.m., Resident #12 | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11

Facility ID:

000443

If continuation sheet

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| IDENTIFICATION NUMBER: A BUILDING D0 COMPILITID OB/14/2011 | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MI | JLTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY | |
|--|--|------------------------------------|-----------------------------|------------|------------|-----------------------------------|---------|------|
| NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR EXCENDENT MUST BE FERCESED BY FULL REGULATORY OR EXC IDENTIFYING BROMANDON) Half side rails in the up position. The gap between the vertical rails appeared to be too large. Measurements were taken of the gaps, on 677/11 at 9.45 a.m. The top half rails had a gap of 7 and 1/8 inches. Bottom half rails were in place on the bed, but not raised. The bottom rails had gaps of 7 and 3/8 inches. Resident #12's clinical record was reviewed on 6/7/11 at 10-10 a.m. The resident was admitted to the facility on 5/13/08. Diagnoses included, but were not limited to, the following: dementia, congestive heart failure, hypertension, dysphagia, hyperlipidemia, osteoarthritis, pacemaker, and macular degeneration. The resident's Fall Risk assessment, dated 5/13/11, indicated a score of 18, with 10 or greater being high risk for falls. The resident's Side Rail assessment, dated 5/13/11, indicated the resident was using top 1/2 rails, had made no attempts to climb over the side rails, and indicated the use of diuretics would require safety precautions. The physician's orders, signed 4/15/11, indicated an order for bilateral top 1/2 side rails as needed while in bed as an enabler. Resident #12's most recent quarterly Minimum Data Set [MIDS] assessment, | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | Δ RIIII | DING | 00 | COMPL | ETED |
| NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED (A) ID SUMMANS STATEMENT OF DETICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG WAS observed to be in bed with the top half side rails in the up position. The gap between the vertical rails appeared to be too large. Measurements were taken of the gaps, on 6/7/11 at 9/45 a.m. The top half rails had a gap of 7 and 1/8 inches. Bottom half rails were in place on the bed, but not raised. The bottom rails had gaps of 7 and 3/8 inches. Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. The resident was admitted to the facility on 5/13/08. Diagnoses included, but were not limited to, the following: dementia, congestive heart failure, hypertension, dysphagia, hyperlipidemia, osteoarthritis, pacemaker, and macular degeneration. The resident's Fall Risk assessment, dated 5/13/11, indicated a corc of 18, with 10 or greater being high risk for falls. The resident's Side Rail assessment, dated 5/19/11, indicated the resident was using top 1/2 rails, had made no attempts to climb over the side rails, and indicated the use of diurcties would require safety precautions. The physician's orders, signed 4/15/11, indicated an order for bilateral top 1/2 side rails as needed while in bed as an enabler. Resident #12's most recent quarterly Minimum Data Set [MIDS] assessment, | | | 15E359 | | | | 06/14/2 | 011 |
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| ST JOHNS HOME FOR THE AGED EVANSVILLE, IN47714 | NAME OF I | PROVIDER OR SUPPLIEF | 8 | | 1236 LI | NCOLN AVENUE | | |
| PREFIX TAG REGULENCY MUST BE PRECEDED BY FULL REGULENCY AND COMPLETION CROSS. DEPENDENCY OF THE APPROPRIATE COMPLETION DATE REGULATORY OR LIC DEDITIFYING INFORMATION TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEDITIFYING INFORMATION TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE REGULATORY OR LIC DEDITIFYING INFORMATION TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEDITIFYING INFORMATION TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEDITIFYING INFORMATION TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEDITIFYING INFORMATION TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEPUTED THE TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEPUTED THE TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEPUTED THE TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEPUTED THE TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LIC DEPUTED THE TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG SHEPPENDER OF THE APPROPPENDER OF THE APPROPRIATE COMPLETION DATE TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG SHEPENDER OF THE APPROPRIATE COMPLETION DATE TAG SHEPPENDER OF THE APPROPRIATE COMPLETION DATE TAG SHEPPENDER OF THE APPROPRIATE CO | | NS HOME FOR THE | AGED | | EVANS' | | | |
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| but not raised. The bottom rails had gaps of 7 and 3/8 inches. Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. The resident was admitted to the facility on 5/13/08. Diagnoses included, but were not limited to, the following: dementia, congestive heart failure, hypertension, dysphagia, hyperlipidemia, osteoarthritis, pacemaker, and macular degeneration. The resident's Fall Risk assessment, dated 5/13/11, indicated a score of 18, with 10 or greater being high risk for falls. The resident's Side Rail assessment, dated 5/19/11, indicated the resident was using top 1/2 rails, had made no attempts to climb over the side rails, and indicated the use of diuretics would require safety precautions. The physician's orders, signed 4/15/11, indicated an order for bilateral top 1/2 side rails as needed while in bed as an enabler. Resident #12's most recent quarterly Minimum Data Set [MDS] assessment, | | half rails had a g | ap of 7 and 1/8 inches. | | | | | |
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| in bed as an enabler. Resident #12's most recent quarterly Minimum Data Set [MDS] assessment, | | 1 - | | | | | | |
| Resident #12's most recent quarterly Minimum Data Set [MDS] assessment, | | _ | | | | | | |
| Minimum Data Set [MDS] assessment, | | in bed as an enal | oler. | | | | | |
| Minimum Data Set [MDS] assessment, | | | | | | | | |
| | | Resident #12's m | nost recent quarterly | | | | | |
| | | Minimum Data S | Set [MDS] assessment, | | | | | |
| dated 5/19/11, indicated the resident | | | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 06/14/2011 | | | |
|---|--|---|---|---|--------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) | DULD BE COMPLETION | | |
| | for transfers. Th 5/17/11, indicate used as needed for resident could not assessment also is experienced falls assessment, with A3. The clinical was reviewed on Resident #15 was at 9:50 A.M., lyis side with bilatera position. In an interview wat 9:50 A.M., she #15 was not interside rails when in The April 2011 Fisheet indicated Rediagnoses which limited to, Alzhe osteoporosis. The Recap further into have "bilateral needed while in the state of the state o | record of Resident #15 06/07/11 at 3:15 P.M. s observed, on 06/06/11 ing in bed on her right al top 1/2 rails in the up with the DoN, on 06/06/11 e indicated that Resident reviewable and used 1/2 in bed. Physician's Recap order desident #15 had included, but were not imer's Dementia and the April 2011 Physician's dicated Resident #15 was I top 1/2 siderails [sic] as the das an enablertabs recliner to alert staff to | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: | | (X2) MI A. BUII | | NSTRUCTION 00 | (X3) DATE SURV COMPLETEI | | |
|--|---|--|--------|---------------|--|------------|------|
| | | 15E359 | B. WIN | | | 06/14/2011 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHN | IS HOME FOR THE | AGED | | | NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | | |
| | The Side Rail Assessment, dated | | | 1710 | | | DITE |
| | 04/21/11, indicated "Side rails are indicated and serve as an enabler to | | | | | | |
| | | | | | | | |
| | promote indepen | dence." | | | | | |
| | | | | | | | |
| | - | or of Nursing] provided | | | | | |
| | · | 7/11, of residents who | | | | | |
| | were currently us | • | | | | | |
| | | P.M. The list included, | | | | | |
| | but was not limited to, the name of Resident #15, with a typed notation which | | | | | | |
| | indicated Resident #15 "will assist if | | | | | | |
| | hands placed on | | | | | | |
| | 1 | | | | | | |
| | The slats of the s | ide rails on the bed of | | | | | |
| | Resident #15 wer | re observed, on 06/07/11 | | | | | |
| | · | be up to 7 and 3/8 | | | | | |
| | inches in width. | | | | | | |
| ı | A4. During obse | ervation on 06/07/11 | | | | | |
| | _ | .M. a review of all | | | | | |
| | _ | cility was conducted. All | | | | | |
| | | re observed, and gaps | | | | | |
| | between vertical | slats in the side rails | | | | | |
| | | /4 inches, as much as 7 | | | | | |
| | | The following additional | | | | | |
| | | gaps exceeding 4 and | | | | | |
| | | g the residents at risk for | | | | | |
| | entrapment of bo | | | | | | |
| | • | ats #41, #10, and #23 | | | | | |
| | 1 1 | mple Residents #14, #21, 5, #19, #20, #5, #13, #18, | | | | | |
| | | #35, #1, #37, #11. | | | | | |
| | , ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, , | 1130, 111, 1131, 1111. | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED COMPLETED | | | | | |
|--|---|---|---------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | 15E359 | A. BUII | | | 06/14/2 | |
| | | 102000 | B. WIN | | A DDDEGG CITY GTATE ZID CODE | 00/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | ew with the DoN | | | | | |
| | [Director of Nursing] on 06/06/11 at | | | | | | |
| | · · | indicated Resident #9 | | | | | |
| | | vable, had fallen in the | | | | | |
| | 1 | nd alarms were not | | | | | |
| | effective as a fall | prevention intervention. | | | | | |
| | The clinical reco | rd of Resident # 9 was | | | | | |
| | reviewed on 06/0 | 07/11 at 11:15 A.M. | | | | | |
| | The May 2011 Physician's Recaps indicated Resident #9's diagnoses | | | | | | |
| | | | | | | | |
| | | re not limited to, chronic | | | | | |
| | · · | pain, and "history of | | | | | |
| | | oma." The record did not | | | | | |
| | | subdural hematoma | | | | | |
| | | ecaps further indicated, | | | | | |
| | | erty] bilateral 1/2 | | | | | |
| | siderails [sic] as | • • | | | | | |
| | The most | MDC [Minimum Data | | | | | |
| | | MDS [Minimum Data | | | | | |
| | Set Assessment], | · · | | | | | |
| | | sident #9 required | | | | | |
| | | of one for bed mobility | | | | | |
| | | had experienced two falls | | | | | |
| | since the last asso | essment. | | | | | |
| | The most recent | Side Rail Assessment, | | | | | |
| | dated 04/14/11, i | ncluded questions to be | | | | | |
| | answered yes or | no. The questions | | | | | |
| | included, but we | re not limited to: "6. | | | | | |
| | Does the resident | t have a history of falls? | | | | | |
| | Yes8. Does the | e resident use the side | | | | | |
| | rails for positioni | ing or support? No11. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E359 | | A. BUIL | DING | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|---|---|---|--------|--------------------|--|----------|--------------------|
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEI | ₹ | | | NCOLN AVENUE | | |
| ST JOHN | NS HOME FOR THE | AGED | | EVANS' | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN | | | |
| PREFIX TAG | ` | ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΤE | COMPLETION DATE |
| IAG | + | e (reason to believe) the | - | IAG | | | DATE |
| | resident has (or may have) a desire or | | | | | | |
| | , | of bed? If YES, explain | | | | | |
| | Nocturnal toileti | | | | | | |
| | | er indicated, "Side rails | | | | | |
| | | d serve as an enabler to | | | | | |
| | promote indeper | | | | | | |
| | | | | | | | |
| | The most recent | care plan, updated | | | | | |
| | | cated a problem of, | | | | | |
| | "potential for falls: last documented falls: 03/04/11 [line struck through] | | | | | | |
| | | | | | | | |
| | 03/05/11 [line st | ruck through] and a | | | | | |
| | handwritten note | e indicated, 05/27/11. The | | | | | |
| | care plan interve | entions were: "Ensure | | | | | |
| | frequently used: | items are within [name of | | | | | |
| | Resident #9] eas | y reach, encourage [name | | | | | |
| | of resident #9], | .ensure [name of | | | | | |
| | _ | request assist with | | | | | |
| | | ion as needed,ensure | | | | | |
| | _ | nt #9] has easy access to | | | | | |
| | 1 | re [name of Resident #9] | | | | | |
| | | priate, non-slip footwear, | | | | | |
| | 1 | Resident #9] area is free | | | | | |
| | | [Physician] to perform | | | | | |
| | | ew and handwritten note | | | | | |
| | dated 05/27/11 i | | | | | | |
| | 1 - 1 | d Count-a lab test], CMP | | | | | |
| | 1 | bolic Profile- a lab test]." | | | | | |
| | | tervention list lacked | | | | | |
| | | of additional interventions | | | | | |
| | to prevent furthe | er rans. | | | | | |
| | An additional pr | oblem, updated 04/14/11, | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LWB11 Facility ID:

000443

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUILDING | 00 | СОМ | (X3) DATE SURVEY COMPLETED 06/14/2011 | |
|--|---|--|--------------|---|---------------------------------------|--------------------|
| | PROVIDER OR SUPPLIER | | 1236 | T ADDRESS, CITY, STATE, ZIP (LINCOLN AVENUE ISVILLE, IN47714 | | /2511 |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD BE | (X5) COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE |
| | for "requires as characterized by positioning, loco related to following forgetfulness and interventions inclimited to, "bilate when in bed as entered to following forgetfulness and interventions inclimited to, "bilate when in bed as entered to provide the following when in bed as entered to provide the following to provide the facing bathroom to provide the following bathroom to provide the following to provide the facing bathroom to provide the facing bath | the following function: motion/ambulation mg functions: larisk for falls." The luded, but were not eral top half rails utilized mabler." es, dated 12/10/10 at 8:45 "Summed [sic] to the ground resident lying on ith lounger and head door" The Nursing documentation of prevent further falls. es dated 12/17/10 at 5:15 "Another residents [sic] otified [name of staff resident was on the | | | | |
| | initiated as the re [centimeter] in di just to the right o | cular [sic] checks were sident has a one cm ameter purple raised area f the posterior skull | | | | |
| | Nurse's Note, on indicated, "Found the middle of the sideGrippy soo | | | | | |
| | 2010, provided b | ents Log for December y the DoN on 06/07/11 luded, but was not | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11

Facility ID:

000443 If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|--|--|--|----------------------------------|----------------|---|----|--------------------|
| THISTERN | or conduction | 15E359 | A. BUILDING B. WING 00 06/14/2 | | | | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | NCOLN AVENUE | | |
| | IS HOME FOR THE | | | 1 | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | COMPLETION DATE |
| IAG | | · · · · · · · · · · · · · · · · · · · | - | IAG | Burelinery | | DATE |
| | · · | s r/t [related to] Resident ed: On 12/10/10 at 8:45 | | | | | |
| | | | | | | | |
| | · · | 9, "unwitnessed; found ting in bedroom; wearing | | | | | |
| | · · | read; no aids in use; no | | | | | |
| | _ ^ ^ | nd on 12/17/10 at 5:15 | | | | | |
| | | sed; found on floor; | | | | | |
| | · · | resident states she was | | | | | |
| | 1 | e recliner and it slipped; | | | | | |
| | " | o ambulation aids in use; | | | | | |
| | no alarms in use; 1 cm [centimeter] bruise | | | | | | |
| | to (R) [right] side of head." On 12/17/10 | | | | | | |
| | ` ' | sident #9 experienced, | | | | | |
| | · · | ound on floor; unknown | | | | | |
| | | oes not remember what | | | | | |
| | she was doing pr | ior to fall; wearing | | | | | |
| | knee-high nylons | s; no ambulation aids in | | | | | |
| | use; no alarms in | use." | | | | | |
| | The Nurse's Note | es, dated 01/08/11 at 7:00 | | | | | |
| | P.M., indicated, ' | calling for help, found | | | | | |
| | on floor by doors | way entrance" The | | | | | |
| | Nurse's Notes an | d the care plan lacked | | | | | |
| | any documentation | on of an intervention to | | | | | |
| | prevent further fa | alls. | | | | | |
| | The Nurse's Note | es, dated 1/31/11 at 7:00 | | | | | |
| | P.M., indicated " | Summoned to room per | | | | | |
| | CNA-Resident w | as on the floor in a | | | | | |
| | supine position | resident stated she was | | | | | |
| | getting ready for | bed and sitting on the | | | | | |
| | edge of the bed a | and slipped to the floor. | | | | | |
| | Resident was bar | refooted. Gripper socks | | | | | |
| | were applied before | ore standing" | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X: | | | X3) DATE SURVEY | | |
|---|---------------------------------------|--------------------------------|---|----------|--------------------------------|------------|------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | | | |
| | | 15E359 | B. WIN | | | 06/14/2011 | |
| NAME OF I | PROVIDER OR SUPPLIEF | " ? | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 1 | NCOLN AVENUE | | |
| ST JOHN | NS HOME FOR THE | EAGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | ICY MUST BE PERCEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIAGE DEFICIENCY) | | ΓE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | | | | | | | |
| | A Falls and Incidents Log for January | | | | | | |
| | | by the DoN on 06/07/11 at | | | | | |
| | | ded, but was not limited | | | | | |
| | | lated to] Resident #9 | | | | | |
| | | Resident #9 experienced, | | | | | |
| | | 0 P.M. Unwitnessed; | | | | | |
| | | ost balance, getting up | | | | | |
| | | lchair; wearing shoes; | | | | | |
| | wheelchair in us | e." On 01/31/11 at 7:00 | | | | | |
| | P.M., "Unwitnessed; found on floor; | | | | | | |
| | slipped off bed; | changing clothes/other | | | | | |
| | ADLs [activities | of daily living]; bare | | | | | |
| | feet; no ambulat | ion aids in use; no alarms | | | | | |
| | in use." | | | | | | |
| | | | | | | | |
| | The Nurse's Not | es, dated 03/04/11 at 5:00 | | | | | |
| | P.M., indicated, | "Disgrundled [sic] | | | | | |
| | wanting someon | e with her on a 1:1. CNA | | | | | |
| | keeps pushing he | er in the w/c [wheelchair] | | | | | |
| | around and arou | nd the unit." Another | | | | | |
| | Nurse's Note, da | ted 03/04/11 at 6:50 | | | | | |
| | • | "Heard yelling from her | | | | | |
| | 1 ' | on the floor in front of | | | | | |
| | | Nursing Notes and care | | | | | |
| | | documentation of an | | | | | |
| | | revent further falls. | | | | | |
| | | | | | | | |
| | The Nurse's Not | es, dated 03/05/11 at 4:50 | | | | | |
| | | "CNAcalled me that | | | | | |
| | | t] called. Was on the | | | | | |
| | I - | oward her bed sitting on | | | | | |
| | | of Resident] said that | | | | | |
| | | ed which would have | | | | | |
| | I she sha out of be | oa willon would liave | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LWB11 Facility ID:

000443

If continuation sheet

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | li i | e survey pleted /2011 |
|--------------------------|--|--|---------------------------------------|---|----------|-----------------------------|
| | PROVIDER OR SUPPLIER | | STREET 1236 I | ^ADDRESS, CITY, STATE, ZIP C LINCOLN AVENUE SVILLE, IN47714 | ODE | |
| (X4) ID PREFIX TAG | regulatory or pointed her feet i said she hit her h notes and care pl documentation the been initiated to | nat an intervention had prevent further falls. | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | provided by the I P.M., included, b "03/04/11 at 6:50 found on floor;tra wearing shoes; n use," and 03/05/ "Unwitnessed; for | dents Log for March 2011, DoN on 06/07/11 at 2:00 but was not limited to, D.P.M. "Unwitnessed; ansferring on/off toilet; to ambulation aids in 11 at 4:50 P.M., bund on floor; ambulating earing shoes, wheelchair | | | | |
| | P.M., indicated, 'on floor on butto straight out and be When questioned of the bed.' The | es, dated 5/13/11 at 4:00 'Resident found sitting ck's [sic] with feet back against her bed. It resident said 'I just slid nursing note and care nterventions added to alls. | | | | |
| | P.M., indicated, 'volunteer and die Resident sitting or recliner" The relacked any docur | es, dated 05/27/11 at 3:40 'Nurse called to room per etary emp [employee] on floor in front of notes and care plan mentation of an revent further falls. | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | Ì | | ONSTRUCTION 00 | (X3) DATE : COMPL | | | |
|--|--|--|---------------------|-------------------|---|---|--------------------|--|
| | | 15E359 | A. BUILDING B. WING | | | 1 | 06/14/2011 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | NCOLN AVENUE | | | |
| | IS HOME FOR THE | | | 1 | VILLE, IN47714 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | COMPLETION DATE | |
| IAG | | · · · · · · · · · · · · · · · · · · · | | IAG | DEFICIENCE TY | | DATE | |
| | | lents Log for May 2011, DoN on 06/07/11 at 2:00 | | | | | | |
| | 1 | out was not limited to, | | | | | | |
| | l ' | M., "Unwitnessed; | | | | | | |
| | | or; slipped while sitting | | | | | | |
| | | e bed; wearing shoes; | | | | | | |
| | | e; half length top side | | | | | | |
| | | er; alarm not in use," and | | | | | | |
| | _ | P.M. Unwitnessed; | | | | | | |
| | | or; states slid out of | | | | | | |
| | | or; wear plain socks; no | | | | | | |
| | ambulation aids in use; no alarms in use." | | | | | | | |
| | | • • • • • • • • • | | | | | | |
| | In an interview w | with the DoN, on 06/07/11 | | | | | | |
| | at 1:00 P.M., she | indicated she would not | | | | | | |
| | be able to provid | e documentation of | | | | | | |
| | specific intervent | tions for each fall. She | | | | | | |
| | further indicted s | he would check the lab | | | | | | |
| | book to see if lab | s were done, but if they | | | | | | |
| | were not there, sl | he would not be able to | | | | | | |
| | provide documer | ntation of interventions. | | | | | | |
| | | | | | | | | |
| | | falls was provided by the | | | | | | |
| | | at 2:00 P.M. The care | | | | | | |
| | _ | 1/11, indicated a problem | | | | | | |
| | 1 - | fall" with interventions | | | | | | |
| | | t limited to, "ensure | | | | | | |
| | | easy reach, encourage | | | | | | |
| | to request assis | | | | | | | |
| | | on as need -5/13 fall, | | | | | | |
| | · · | access to call light, | | | | | | |
| | | ng appropriate, no-slip | | | | | | |
| | | Cootwear, ensurearea is | | | | | | |
| | tree of clutter, M | D to perform medication | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MU A. BUIL | | onstruction 00 | (X3) DATE S | ETED | |
|--|--|--|---------|-------------------|---|---------|------------|
| | | 15E359 | B. WING | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | | | 1236 LI | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | `` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| IAG | | , | | TAG | DEFICIENCY) | | DATE |
| | | CBC [complete blood | | | | | |
| | count], CMP [complete metabolic panel]." | | | | | | |
| | panerj. | | | | | | |
| | On 06/07/11 at 2:00 P.M., the DoN | | | | | | |
| | provided a timeli | · | | | | | |
| | 1 * | Resident #9. The | | | | | |
| | | d, "For falls 3/4/11 and | | | | | |
| | | dication] review. Ativan | | | | | |
| | was decreased from | om 0.5 mg to .25 mg at 5 | | | | | |
| | P.M. On 03/08/1 | 1/[sic] For Fall 5-13-11, | | | | | |
| | encourage [name | of resident] to request | | | | | |
| | | ers/ambulation. See Care | | | | | |
| | _ | /11. For Fall 5-27-11. | | | | | |
| | CBC. CMP." | | | | | | |
| | El D'MED. | (2) | | | | | |
| | - | for of Nursing] provided | | | | | |
| | l ' | 7/11, of residents who | | | | | |
| | were currently us | P.M. The list included, | | | | | |
| | | ed to, the name of | | | | | |
| | Resident #9. | cu to, the hame of | | | | | |
| | reordent 117. | | | | | | |
| | A6. Resident #2 | 28's clinical record was | | | | | |
| | | 11 at 3:25 p.m. The | | | | | |
| | | nitted to the facility on | | | | | |
| | | gnoses including, but not | | | | | |
| | limited to, Alzhe | imer's Disease and | | | | | |
| | osteoporosis. Th | e resident's last full | | | | | |
| | Minimum Data S | Set [MDS] assessment, a | | | | | |
| | - | ge assessment, was dated | | | | | |
| | | essment indicated the | | | | | |
| | _ | total assistance of two | | | | | |
| | staff for transfers | , and was unable to | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11 Facility ID:

000443 If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|--|--|--|------------|--------------|--|---------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST IOUN | IS HOME FOR THE | AGED | | 1 | NCOLN AVENUE VILLE, IN47714 | | |
| | | | | | VILLE, IN477 14 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION DATE |
| mo | | ssessment indicated he | + | 1710 | <u> </u> | | DATE |
| | | | | | | | |
| | had falls since the previous assessment, with no injury. The assessment indicated | | | | | | |
| | he utilized bed rails. | | | | | | |
| | inc utilized bed la | шъ. | | | | | |
| | Resident #28's Side Rail Assessment, | | | | | | |
| | | · | | | | | |
| | • | dicated the resident had vels of consciousness or | | | | | |
| | | | | | | | |
| | - | it related to a dementia | | | | | |
| | diagnosis, had visual deficits, was able to get in/out of bed, was not able to get out | | | | | | |
| | | | | | | | |
| | • | d a history of falls, used | | | | | |
| | | elp rise from a supine | | | | | |
| | - | ng/standing position, had | | | | | |
| | • | climb over the side rails, | | | | | |
| | | idence the resident had a | | | | | |
| | desire or reason t | • | | | | | |
| | | g. The recommendations | | | | | |
| | _ | rails to serve as an | | | | | |
| | enabler to promo | ite independence. | | | | | |
| | | | | | | | |
| | | rsonal Alarm Assessment | | | | | |
| | | 1. It indicated the date of | | | | | |
| | | 18/11 and a history of | | | | | |
| | • | he assessment failed to | | | | | |
| | | behaviors" of trying to | | | | | |
| | | walk alone, or trying to | | | | | |
| | - | safely. The assessment | | | | | |
| | - | lems with walking, | | | | | |
| | - | g, communication, and | | | | | |
| | _ | The determination was | | | | | |
| | | o have a tab alarm at all | | | | | |
| | times. | | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | |
|---|--|--|--------|---------------------|---|------------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | 1 00/11/12 | |
| | | | | EVANS | VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| mg | Resident #28's ca 3/22/11. The car 3/16/11, indicated be used for the received resident #28 had "[Resident's name dementia diagnos and urinary incordocumented fall: Interventions inc "-Tabs/pad alarm to ambulate/transtabs alarm and cl reach to ensure p Quarterly assess for continued ala -Provide [resident transfers/toileting -Ensure [resident non-slip footwea -Ensure that [resident non-slip footwea -Ens | are plan was reviewed on the plan for mobility, dated and a mechanical lift was to esident's transfers. It a care plan as follows: The lift of the li | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUIL | | NSTRUCTION 00 | (X3) DATE S | ETED | |
|--|---|---|---------|---|--|---------|--------------------|
| | | 15E359 | B. WINC | | | 06/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| ST IOHN | IS HOME FOR THE | AGED | | | NCOLN AVENUE VILLE, IN47714 | | |
| | _ | | | | VILLE, IIV T | - | (7/5) |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | · ` | LSC IDENTIFYING INFORMATION) | | TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | DATE |
| | shoulder. Assiste | ed up [with] gait belt and | | İ | | | |
| | iii [three] staff members. At that time, when (R) leg was removed from bed, | | | | | | |
| | | | | | | | |
| | alarm went off. | Resident bed was in | | | | | |
| | lowest position h | ad on gripper socks and | | | | | |
| | alarm working p | roperly." The note was | | | | | |
| | written by a Qua | lified Medication | | | | | |
| | Assistant [QMA] |]. | | | | | |
| | 1/18/11 10:15 p.1 | m. "B/P [blood pressure] | | | | | |
| | 156/90 P [pulse] | 70 R [respirations] 20 T | | | | | |
| | [temperature] 98 | .3 02 [oxygen] sat | | | | | |
| | [saturation] 95% | on RA [room air]. Sr. | | | | | |
| | [Sister] [name of | "nun supervisor] notified, | | | | | |
| | message left on a | answering for POA | | | | | |
| | [power of attorne | ey]." QMA note. | | | | | |
| | | m. "Dr. [name's] office | | | | | |
| | fax regarding fall | l on resident." QMA note | | | | | |
| | 1/19/11 12:00 a.r | n. "Neuro [checks] WNL | | | | | |
| | ~ | mits] B/P 148/80 T. 97.5 | | | | | |
| | | 95% on RA. Resident | | | | | |
| | | Denies discomfort" | | | | | |
| | 2/4/11 11-7 "Res | ident observed | | | | | |
| | | out of bed unassisted | | | | | |
| | several times ear | ly this shift. Denies | | | | | |
| | discomfort. Care | • | | | | | |
| | | emains in place." | | | | | |
| | 3/15/11 11:30 p.r | n. "Resident observed | | | | | |
| | _ | rith] legs off the side of | | | | | |
| | _ | ace. repositioned back to | | | | | |
| | bed." | | | | | | |
| | _ | . "A little restless @ | | | | | |
| | | t, trying to climb out of | | | | | |
| | | om. CNAs assist [with] | | | | | |
| | Hoyer lift to get i | resident up. Toileted and | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE S COMPL - 06/14/2 | ETED | | | |
|---|---|---|---|--|---------|----------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| | put in his wheeld Sitting in commod 4/19/11 11:45 p.m. [with] legs off si [with] placing legalace." 5/1/11 11-7. "Reattempting to get this shift. Legs of back to bed. Derremains in place. 5/4/11 9:30 p.m. res. [resident's] legalace on floor - upper legalace of the shift. Legs of back to bed. Derremains in place. 5/4/11 9:30 p.m. res. [resident's] legalace on floor - upper legalace of the shift. Derremains in place. It is a shift of the shift | chair. Much calmer. on area watching T.V" m. "Resident observed de of bed. Assisted gs back on bedalarm in esident has been observed fout of bed @ X's [times] off side of bed, assisted mies discomfort. Alarm "" "Tab alarm set off found ower body on (R) knee body in bed. (R) knee er bruises or O/A [open Assist back to bed tab 40/78 T 98.8 P 93 R 20 mair. Has been more "" "I. "CNA observed to put legs over side of at back to bed. Tab alarm "" "I. "Dr. [name] notified e of nun supervisor] "I. "Resident trying to again." "I. "Once in bed, tried X ad. Alarm in place and | | | | | | |

000443

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|--|--------------------------------------|--|-------|---------------|--|------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIER | <u>.</u> | -! | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | NS HOME FOR THE | | | l | NCOLN AVENUE VILLE, IN47714 | | |
| | | | | | VILLE, IN477 14 | | ave) |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | DATE |
| | pressing against | side rail. Bed in low | | | | | |
| | position. TAB monitor on and did not | | | | | | |
| | engage. ROM [range of motion] adeq. | | | | | | |
| | [adequate] to all | | | | | | |
| | 1 | n. "Attempting to climb | | | | | |
| | | Set tabs monitor off. | | | | | |
| | Wanting to go fi | | | | | | |
| | | "During routine bed | | | | | |
| | · · | observed sitting upright on | | | | | |
| | | Bed in lowest position. | | | | | |
| | | hed, did not pull away to | | | | | |
| | l . | active range of motion] | | | | | |
| | · - | vithout] difficulty. ort. B/P 124/70 T 98 P 76 | | | | | |
| | | % RA. Assisted to | | | | | |
| | | n per (3) assist and gait | | | | | |
| | 1 | bed. [No] redness noted | | | | | |
| | | ick. Alarm positioned to | | | | | |
| | | bed and attached to | | | | | |
| | | hirt. Encouraged call | | | | | |
| | light use." | C | | | | | |
| | | | | | | | |
| | The Immediate J | leopardy began on 6/7/11, | | | | | |
| | when side rails v | vere observed to have | | | | | |
| | gaps between the | e vertical slats that | | | | | |
| | measured greate | r than 4 and 3/4 inches, | | | | | |
| | with potential fo | r head/neck/or limb | | | | | |
| | _ | e Administrator, DoN and | | | | | |
| | | facility were made aware | | | | | |
| | | e Jeopardy on 6/7/11 at | | | | | |
| | _ | d to side rails having gaps | | | | | |
| | 1 | eater than 4 and 3/4 | | | | | |
| | _ | ential for entrapment and | | | | | |
| | related to repeate | ed falls for residents at | | | | | |

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Event ID: 5LWB11 Facility ID:

000443

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| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | γ <u>(</u> Σ | (2) MULTIP | | | | (X3) DATE | |
|------------|---------------------------------------|-----------------------------|--------------|--------------------|------------|-------------------|--|-----------|--------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A | . BUILDING | | 00 | | COMPL | |
| | | 15E359 | В | . WING | | | | 06/14/2 | UII |
| NAME OF I | PROVIDER OR SUPPLIEF | | | | | DRESS, CITY, STAT | | | |
| | | | | | | OLN AVENUE | | | |
| | IS HOME FOR THE | | | | ANSVIL | LE, IN47714 | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | | | AN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FU | I . | PREF | - 1 | CROSS-REFERENCED | ACTION SHOULD BE O TO THE APPROPRIAT CIENCY) | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATIO | UN) | TAC | J | DEFIC | ALINC I J | | DATE |
| | risk for falls with | | | | | | | | |
| | interventions to deal with the falls. | | | | | | | | |
| | | ved on 6/11/11, when | . | | | | | | |
| | _ | tion, interview and recor | | | | | | | |
| | · · | etermined that the facilit | ty | | | | | | |
| | _ | d the plan of action to | | | | | | | |
| | | ediate Jeopardy and that | | | | | | | |
| | 1 ^ | emoved the immediacy of | of | | | | | | |
| | the problem. | | | | | | | | |
| | | ide rail gaps being | | | | | | | |
| | | entrapment could not | | | | | | | |
| | · · | order confirmation of | | | | | | | |
| | manufacturer kit | s to fix the side rail gaps | s, | | | | | | |
| | review of record | s for appropriate side rai | i1 | | | | | | |
| | assessments, fall | risk assessments, and | | | | | | | |
| | revision in interv | ventions for fall | | | | | | | |
| | prevention, indic | cated the facility had | | | | | | | |
| | removed the imn | nediacy of the problem. | | | | | | | |
| | | facility's corrective | | | | | | | |
| | _ | the IJ, the facility | | | | | | | |
| | | compliance at a reduced | | | | | | | |
| | | ty level of pattern no | | | | | | | |
| | _ | the potential for more | | | | | | | |
| | than minimal ha | - | | | | | | | |
| | | | | | | | | | |
| | B1. On 6/8/11 a | t 12:55 p.m., RN #1 was | . | | | | | | |
| | | a medication pass on the | | | | | | | |
| | l | The medication cart was | | | | | | | |
| | _ | e a plastic container with | | | | | | | |
| | | holes. The RN had | | | | | | | |
| | | set up in the holes with | | | | | | | |
| | | ged medications in the | | | | | | | |
| | | resident names in front | | | | | | | |
| | | ring interview at that | | | | | | | |
| FORM CREE | | | ID | | 71: 775 | | TC | | |
| FORM CMS-2 | 2567(02-99) Previous Version | ons Obsolete Event | ID: 5LW | 'B11 ^{Fa} | cility ID: | 000443 | If continuation sh | neet Par | ge 77 of 122 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIP! A. BUILDING B. WING | | NSTRUCTION 00 | (X3) DATE: COMPL 06/14/2 | ETED | | |
|---|---|---|---|----------------|---|------|--------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | ID PREFI | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | (X5) COMPLETION | |
| TAG | time, she indicate | ed they were the was preparing to give. | TAC | | DEFICIENCY) | | DATE | |
| | administer medic | - | | | | | | |
| | #41's room to ad: 1:02 p.m. She w | rved entering Resident minister medications at as out of sight of the with medications setting | | | | | | |
| | #30's room at 1:0 | eved entering Resident 04 p.m. The medication ght of the RN, with op of the cart. | | | | | | |
| | general environm Administrator, the observed in the s Joseph Unit, in a which was unloce -a plastic squirt thand written on the During an intervi | oiled utility room on St. cabinet under the sink, ked and unattended: oottle with a green liquid, he bottle was "Odoban." few at that time, the | | | | | | |
| | deodorizer. Duri time, the Housek indicated, at 11:4 | dicated it must be an air ing an interview at that eeping Supervisor 0 a.m., the company abels for the smaller | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | COMPI | | |
|--|----------------------|------------------------------|--------|---------------|---|---------|------------|
| 111,1212111 | or condition, | 15E359 | | LDING | | 06/14/2 | |
| | | | B. WIN | | DDRESS, CITY, STATE, ZIP CODE | 1 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1 | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | 1 | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENC!) | | DATE |
| | | ated for them to write the | | | | | |
| | product name on | | | | | | |
| | l * | er. The label was | | | | | |
| | | larger bottles. A label | | | | | |
| | | 11:50 a.m. and indicated | | | | | |
| | | e avoided with eyes, skin | | | | | |
| | l - | t aid for ingestion was to | | | | | |
| | 1 | n or poison control center, | | | | | |
| | drink 1 or 2 glass | | | | | | |
| | | o-quat, a sanitizing | | | | | |
| | · · | was hooked to the sink | | | | | |
| | | led causes respirator | | | | | |
| | ' " | act, eye and skin burns. | | | | | |
| | Harmful if swall | | | | | | |
| | | Hawaiian breeze, labeled | | | | | |
| | "Keep out of rea | | | | | | |
| | 1 * * | Hot Shot" Roach and Ant | | | | | |
| | | f swallowed, immediately | | | | | |
| | call poison contr | ol." | | | | | |
| | B3. On 6/10/11 | at 11:10 a.m., the | | | | | |
| | Therapy room, lo | ocated on the first floor | | | | | |
| | across from the o | chapel, was unlocked and | | | | | |
| | unattended. No | residents were in the | | | | | |
| | vicinity. A hydro | oculator [a device used to | | | | | |
| | keep hot packs h | ot], was in the room, | | | | | |
| | turned on, and f | ull of water and hot | | | | | |
| | packs. The hydr | oculator had a lid on it | | | | | |
| | with a handle an | d easily opened. The | | | | | |
| | water temperatur | e inside was measured at | | | | | |
| | 166 degrees Fahr | renheit. Residents on all | | | | | |
| | three units would | | | | | | |
| | The Director of 1 | Nurses indicated, during | | | | | |
| | | | | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| l | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE COMPI 06/14/2 | LETED |
|--------------------------|---|---|--|--|-------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | Therapist had just and usually locked at that Nurses indicated with cognitive in wanderers" at the B4. Review of the provided by the 16/6/11 at 12:30 p | he Resident Roster, Director of Nurses on o.m., 30 of the 42 ocumented as having | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M A. BUI | | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--------|------------------|---|--|------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER IS HOME FOR THE SUMMARY S' | | · · | 1236 LI EVANS | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| (X4) ID | SUMMARY S' (EACH DEFICIENCE REGULATORY OR The facility must p sufficient fluid intal hydration and heal Based on observa record review, th 1 of 3 sampled re hydration, in the provided with suffluids were not al contact with the r water was not off (Resident #41) Finding includes: Resident #41's cl reviewed on 6/6/ resident was adm 4/14/04. Diagno not limited to, Gl atherosclerosis, c macular degenera congestive heart depression. The orders, signed 5/ not limited to, De The resident's car had a focus/probl name] has the po fluid maintenance | ratement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) rovide each resident with ke to maintain proper lth. ation, interview and e facility failed to ensure esidents reviewed for sample of 11, was fficient fluids, in that lways offered when resident, and sufficient fered with medications. | FO | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | held 7, 011, on in fic was eld on e d if | |
| | | ed use and diagnoses of heart failure], | | | | | |

000443

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE: COMPL 06/14/2 | ETED | |
|---|--|--|----------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIEF | | • | 1236 LII | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | following: "-Give [resident' [milligrams] PO orders, provide profile followed of fluid deficit/over edema, dry mouturinary output et -Give [resident's chloride] 10 medially." The most recent dated 5/5/11. The Nitrogen [BUN] normal ranges of Creatinine was swith normal ranges with normal range with normal range of seated in a reclim mumbling. She Styrofoam cup of her. She had had an anti-contracturinterview at that Nurses indicated followed on their and had lost weig supplements. | laboratory reports were the resident's Blood Urea was elevated at 44, with f 7 to 18. The resident's lightly elevated at 1.3, ge from 0.6 to 1.1. s observed, during the f6/11 at 9:50 a.m., to be the chair in her room, | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUII | | ONSTRUCTION 00 | (X3) DATE S | ETED | |
|---|---|------------------------------|--------|-----------------|--|---------|------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHN | IS HOME FOR THE | AGED | | | NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | 8:40 a.m. to be in her recliner chair again. CNA #3 was observed in the room with the resident. The CNA offered to toilet the resident. CNA #5 and CNA #3 | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | ent to the bathroom and | | | | | |
| | | ner chair. No fluids were | | | | | |
| | observed offered | | | | | | |
| | | | | | | | |
| | On 6/8/11 at 6:30 | p.m., Resident #41 was | | | | | |
| | observed in the s | mall dining room. She | | | | | |
| | had been fed her | evening meal. A six | | | | | |
| | ounce cup of app | le juice was in front of | | | | | |
| | the resident. Thr | ree [3] ounces were left. | | | | | |
| | On 6/0/11 at 9:50 |) a.m., RN #1 was | | | | | |
| | | inister medications to | | | | | |
| | | ne administered oral | | | | | |
| | medications with | | | | | | |
| | | t ounces. She brought in | | | | | |
| | | r, gave the resident one | | | | | |
| | ounce and then the | • • | | | | | |
| | | | | | | | |
| | | 20 p.m., Resident #41 | | | | | |
| | | dining room with her | | | | | |
| | · · | ounce cup of water, with | | | | | |
| | three ounces rem | aining, was observed. | | | | | |
| | On 6/9/11 at 2:25 | 5 p.m., RN #1 was | | | | | |
| | | e indicated, on her unit, | | | | | |
| | | being monitored for | | | | | |
| | · • | t was the resident with a | | | | | |
| | tube feeding (Res | sident #12). They were | | | | | |
| | not monitoring R | lesident #41 for intake | | | | | |
| | and output. | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULT A. BUILDI B. WING | | 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|---|--|--|------|--------------------|--|--|----------------------------|
| | PROVIDER OR SUPPLIER | | | 1236 LIN | DDRESS, CITY, STATE, ZIP CODE ICOLN AVENUE (ILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PR | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| F0332 SS=E | medication error ragreater. Based on observater record review the it was free of a magreater than 5%, medication errors for error, resulting This affected 3 of for medication parameters. (RN Findings include 1. During an observation pass, P.M., RN #1 individuals.) | servation of the on 06/08/11 at 12:00 cated she was preparing dications and through a | F033 | 32 | Mandatory in-services will be on July 7 and July 8, 2011, addressing medication administration, correct time of medications, and omissions of medications. The facility policiand procedure for medication administration will be in-serviced administration will be monitored daily for one mont correct administration of medication. Monitoring will continue twice weekly after the first month. New hires will be in-serviced during orientation ongoing in-servicing will occubi-annually. Consultant pharmacist will perform medication administration revenonthly for three months and then quarterly. The ADON are DON will monitor. Ongoing monitoring for one year. | of of cy n iced. h for he e n, and ur | 07/14/2011 |

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Facility ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE : COMPL | | |
|--|---------------------------------------|------------------------------|------------------|----------------|--|---------|------------|
| | | 15E359 | A. BUI B. WIN | LDING IG | | 06/14/2 | 011 |
| | | II. | D. WII | | ADDRESS, CITY, STATE, ZIP CODE | l | |
| NAME OF 1 | PROVIDER OR SUPPLIEF | { | | 1236 LI | NCOLN AVENUE | | |
| | NS HOME FOR THE | | | | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ГЕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | <u> </u> | la | DATE |
| | 1 | ation for pain] 20 ml [650 | | | Completed date: 07/14/11 N Policy and Procedures were | vew | |
| | 1 - 1 | n a medication cup. RN | | | adopted regarding tube feed | ing | |
| | | to obtain 30 cc [cubic | | | and medication administration | | |
| | _ | vater and place on a small | | | with G-tubes. Mandatory | | |
| | plastic tray for tr | ransport to the resident's | | | in-services were held on Jun | | |
| | room. | | | | June 24, June 27, and will be on July 1, 2011, to review the | | |
| | | | | | policies. All nurses and QMA | | |
| | Resident #12 wa | s observed lying in bed | | | have given a return | *** | |
| | with the head of | bed elevated | | | demonstration of tube feedin | | |
| | approximately 3 | 0 degrees, on 06/08/11 at | | | and medication administration | • | |
| | 12:00 P.M. | | | | the completion date. Any ne hires will be in-serviced durir | | |
| | | | | | their orientation. Ongoing | ig | |
| | RN #1 entered th | ne room of Resident #12 | | | in-services will occur quarter | ly. | |
| | and set the small | tray of prepared | | | Nurses and QMAs will be | • | |
| | | water flush on the bedside | | | observed one time daily for o | ne | |
| | cabinet. | | | | month, and then they will be observed weekly for correct | | |
| | Cuomet. | | | | administering of tube feeding | and | |
| | RN #1 was then | observed to install a 30 | | | medication administration the | | |
| | | eter] air bolus to the open | | | G-tubes. The ADON and DO | | |
| | _ | e. RN #1 was then | | | monitor. Ongoing monitoring | for | |
| | 1 . | | | | one year. Completed date: 07/08/11 | | |
| | | ove the stethoscope from | | | 07/00/11 | | |
| | | and apply the bell of the | | | | | |
| | stethoscope to th | e resident's abdomen. | | | | | |
| | Damin | : DNT#1 | | | | | |
| | | iew, at that time, RN#1 | | | | | |
| | indicated, "Oh, I | neard sounds. | | | | | |
| | DN #1 41 | ahaamad ta amul1 | | | | | |
| | | observed to apply gloves | | | | | |
| | | p in a 60 cc syringe. RN | | | | | |
| | | the Jevity back into the | | | | | |
| | | p of the syringe with a | | | | | |
| | · · · · · · · · · · · · · · · · · · · | serted the tip of the 60 cc | | | | | |
| | syringe into the | open port of the tube. | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE COMPI 06/14/2 | LETED | |
|---|--|---|------|---------------------|---|-------|----------------------------|
| | PROVIDER OR SUPPLIEF | | • | 1236 LII | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | • | |
| (X4) ID PREFIX TAG | SUMMARY S (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | | cated, "I don't know why I rvous after so many | | | | | |
| | MAPAP 20 ml [6 via g-tube withou after the feeding administration. It to fill the open significant of the open significant of the open spilling water an abdomen of Residual manimum of Re | at that time, RN #1 has never happened to me f nursing." cord of Resident #12 was 07/11 at 10:10 A.M. cian's Order Recap s not limited to, orders | | | | | |
| | | eck placement, the failure | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|--|------------------------------------|------------------------------|--------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIII | LDING | 00 | COMPL | ETED |
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | | | _ | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ę. | | 1236 LI | NCOLN AVENUE | | |
| | NS HOME FOR THE | | | | VILLE, IN47714 | | |
| (X4) ID | | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΤE | COMPLETION |
| TAG | + | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENC!) | | DATE |
| | | before and after the | | | | | |
| | | inistration, and the failure | | | | | |
| | 1 | the Tylenol to the | | | | | |
| | 1 | d in three [3] medication | | | | | |
| | errors for this ob | eservation. | | | | | |
| | | | | | | | |
| | On 6/8/11 at 5:5 | 0 p.m., RN #2 was | | | | | |
| | observed admini | stering medications | | | | | |
| | 1 | stomy tube to Resident | | | | | |
| | " " | ations included, but were | | | | | |
| | | anitidine [medication to | | | | | |
| | reduce stomach | - | | | | | |
| | 1 | ne crushed the medication | | | | | |
| | 1 | l one other medication | | | | | |
| | | | | | | | |
| | 1 | c centimeters] of water. | | | | | |
| | | d medication with 10 cc | | | | | |
| | 1 | en placed another 10-15 | | | | | |
| | | medication cup. She | | | | | |
| | 1 | will make the 30 cc | | | | | |
| | flush." She then | poured up 45 cc of | | | | | |
| | Gatorade. Every | thing was placed on a | | | | | |
| | small plastic tray | and taken to Resident | | | | | |
| | #12's bedside. | | | | | | |
| | | | | | | | |
| | RN #2 then took | the plug out of the | | | | | |
| | 1 | e and attached a syringe to | | | | | |
| | 1 " | illed back on the plunger | | | | | |
| | 1 | ered the chamber of the | | | | | |
| | 1 | connected the syringe and | | | | | |
| | 1 ' - | don't get anything back, | | | | | |
| | 1 | | | | | | |
| | maybe a dribble." She proceeded to | | | | | | |
| | 1 | ger from the syringe and | | | | | |
| | 1 ' ' | e to the tube and was | | | | | |
| | preparing to pou | r the medications into the | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | INSTRUCTION 00 | (X3) DATE S COMPL | |
|--|---------------------------------------|--|------------------|--------------|--|----------------------|--------------------|
| | | 15E359 | A. BUI B. WIN | | | 06/14/2 | |
| NAME OF F | PROVIDER OR SUPPLIER | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 1 | NCOLN AVENUE | | |
| | IS HOME FOR THE | | | | VILLE, IN47714 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | 1 | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | tube. At that poi | nt, she was stopped and | | | | | |
| | questioned if she | was able to be sure the | | | | | |
| | | tomach, since there was | | | | | |
| | | indicated she guessed | | | | | |
| | | ure. She then left the | | | | | |
| | | ed a stethoscope, injected | | | | | |
| | | and listened with the | | | | | |
| | stethoscope to se stomach. | e if the air entered the | | | | | |
| | Stomach. | | | | | | |
| | After checking p | lacement of the tube, the | | | | | |
| | • • • • • • • • • • • • • • • • • • • | poured the 10 cc of | | | | | |
| | water with the tw | vo crushed medications | | | | | |
| | into the chamber | of the syringe. No flush | | | | | |
| | was done prior to | the administration. She | | | | | |
| | then administered | d the one medication in | | | | | |
| | | er. When some residual | | | | | |
| | medication was o | | | | | | |
| | 1 | she poured Jevity 1.2 | | | | | |
| | _ | from the can into the | | | | | |
| | | that into the syringe. She | | | | | |
| | 1 | r the rest of the can of e chamber and let it drain | | | | | |
| | 1 1 | by gravity. She followed | | | | | |
| | | the Gatorade, and then | | | | | |
| | | r in the medication cup. | | | | | |
| | | d the syringe and plugged | | | | | |
| | the tube. | | | | | | |
| | | | | | | | |
| | _ | nysician's orders were | | | | | |
| | | 1 at 10:25 a.m. The | | | | | |
| | | s for medications, signed | | | | | |
| | · · | ded, but were not limited | | | | | |
| | to, the following: | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY | |
|--|----------------------|------------------------------|------------|------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | 1 | |
| NAME OF I | PROVIDER OR SUPPLIEF | | | 1236 LI | NCOLN AVENUE | | |
| | NS HOME FOR THE | | | | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | † | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | | mg tablet take 1 tablet per | | | | | |
| | G-tube at bedtim | | | | | | |
| | "Artificial tears | drops instill 2 drops into | | | | | |
| | each eye twice d | aily." | | | | | |
| | The Medication | Administration Record | | | | | |
| | was reviewed, at | the same time, and | | | | | |
| | indicated the Rai | nitidine was scheduled for | | | | | |
| | 9:00 p.m. and the | e Artificial tears were | | | | | |
| | scheduled for 5:0 | | | | | | |
| | | | | | | | |
| | The failure to ch | eck placement, the failure | | | | | |
| | to flush the tube | | | | | | |
| | | Ranitidine given at the | | | | | |
| | | _ | | | | | |
| | | the Artificial Tears | | | | | |
| | | ed in 4 errors during this | | | | | |
| | observation. | | | | | | |
| | The Policy and I | Procedure for | | | | | |
| | Medication-Feed | ling Tube dated 07/2005, | | | | | |
| | provided by the | DoN [Director of | | | | | |
| | 1 - |)9/11 at 1:45 P.M. | | | | | |
| | "" | ttach syringe to end of the | | | | | |
| | | wenty (20) cc of air. a. | | | | | |
| | | t and patency by | | | | | |
| | 1 * | tening for air sounds with | | | | | |
| | the bell of a stetl | | | | | | |
| | | | | | | | |
| | _ | nsert medication by | | | | | |
| | | nto tube8. Flush with | | | | | |
| | thirty (30) cc of | water" | | | | | |
| | The Geriatric Ma | edication Handbook, | | | | | |
| | | reviewed on 6/9/11 at | | | | | |
| | | | | | | | |
| | 1 - | ated the following: | | | | | |
| | Niedication adn | ninistration via enteral | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | |
|--|--|--|--------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | tube placement [milliliters] water tubing using gray dissolved/diluted syringe14. Flu of water, or presonant p | sh tubing with 15-30 ml cribed amount" few with the DoN on D.P.M., she indicated If destions about g-tubes er and she would look on that time, the DoN ources that she had in the m 1980 and 1987. Forning medication pass, 10 A.M., LPN #1 was are and administer Resident #27. The II #1 administered from the modern tends of | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MUI A. BUILE B. WING | DING | NSTRUCTION 00 | (X3) DATE (COMPL 06/14/2 | ETED | |
|--|----------------------|---|------|----------------|--|------|--------------------|
| NAME OF | PROVIDER OR SUPPLIEI | | | STREET A | DDRESS, CITY, STATE, ZIP CODE | l | |
| | | | | | NCOLN AVENUE | | |
| | NS HOME FOR THE | | | | VILLE, IN47714 | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES | | ID REFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) | ' | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | DATE |
| | reviewed on 06/ | 08/11 at 11:00 A.M. The | | | | | |
| | | cian's Recap indicated, | | | | | |
| | 1 ' | g [milligram] tablet take | | | | | |
| | (1) tablet by mor | uth once daily with | | | | | |
| | breakfast for nut | ritional | | | | | |
| | supplementCa | lcium 600 W/D [with | | | | | |
| | | et Take 1 tablet by mouth | | | | | |
| | twice daily with | meals" | | | | | |
| | l | | | | | | |
| | 1 | plied by the DoN | | | | | |
| | I = | sing], on 06/06/11 at | | | | | |
| | 1 | cated breakfast was | | | | | |
| | served at 8:00 A | .IVI. | | | | | |
| | In an interview | with DoN, on 06/09/11 at | | | | | |
| | | ndicated, "We can't give | | | | | |
| | 1 | s, we aren't allowed to | | | | | |
| | pass meds in the | | | | | | |
| | puss meds in the | uning room. | | | | | |
| | A policy and pro | ocedure for Medication | | | | | |
| | | dated 07/2005, was | | | | | |
| | provided by the | DoN on 06/13/11 at 12:10 | | | | | |
| | P.M.; it indicate | d, "8b. Read and follow | | | | | |
| | any special instr | uctions written on | | | | | |
| | labels" | | | | | | |
| | 3. On 6/9/11 at | 8:50 a.m., RN #1 was | | | | | |
| | 1 | stering medications to | | | | | |
| | | he medications included, | | | | | |
| | 1 | ited to, KCL [potassium | | | | | |
| | 1 | q [milliequivalents] one | | | | | |
| | tablet. The RN | | | | | | |
| | | d 1/2 pills, including the | | | | | |
| | | dent, two at a time | | | | | |
| | followed by sips | of a nutritional | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| l | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | i . | e survey pleted /2011 |
|--------------------------|---|--|--|--|----------|-----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP CO NCOLN AVENUE VILLE, IN47714 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | with one ounce of | e last one pill was given of water, from four The additional 3 ounces | | | | |
| | physician's order included, but we | nical record was 11 at 2:35 p.m. The s, signed on 5/19/11, re not limited to, an order po [by mouth] twice | | | | |
| | Handbook, revie a.m., indicated the potassium chloric meals and a full | g Spectrum Drug wed on 6/9/11 at 10:30 ne following regarding de: "Give P.O. form with glass of water or juice, to strointestinal] upset." | | | | |
| | 3.1-25(b)(9) 3.1-48(c)(1) | | | | | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) I | | (X3) DATE S | 3) DATE SURVEY | | |
|--|---|--|----------------|-------------|--|--|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | 00 | COMPLETED | |
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | | | B. ((1)) | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | NCOLN AVENUE | | |
| ST JOHN | IS HOME FOR THE | AGED | | | VILLE, IN47714 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | <u> </u> | TAG | DEFICIENCY) | | DATE |
| F0371 SS=F | The facility must - (1) Procure food for considered satisfal local authorities; a (2) Store, prepare under sanitary corn Based on observer facility failed to prepared, and ser conditions, in that found in the free washed/gloves chactivities and cle kitchen observations are considered activities and cle kitchen observations. This despotential to affect facility who ate in Findings include 1. During observed in the protatoes. He was gloves. He was crim of the trash chand then proceed. During the same kitchen, on 6/9/1 | rom sources approved or actory by Federal, State or and a distribute and serve food additions ation and interview, the ensure food was stored, and activities and activities, for 1 of 1 ion, and 1 of 3 meal ons (Evening meal ficient practice had the tall of 42 residents in the meals from the kitchen. | F0 | 371 | Mandatory in-service was he June 24, and June 27, 2011 dietary employees. Dietary was in-serviced on the preparation, storage, and se of food. The facility has a po and procedure on reception use of food items. Inventory be maintained on receipt and usage dates. Designated employees have been in-serviced, on "first-in, first-procedure. Older food items be monitored weekly when the main food order arrives. Old food items will be moved to a front and items nearing their expiration date, or food items appear to be close to expirate regardless of the date, will be relocated to a designated radiumediate usage or disposa. The dietary manager, or designate, will make the decon whether the food item will used or disposed. Donated will be transported in an air conditioned van. A cooler will freezer ice packs will be use needed. Mandatory in-service be held on July 5 and July 7 2011, for all dietary employe | eld on for all staff rving licy and will destroy the ler the ler ck for l. ision l be food the different will second the different ler ck. | DATE 07/07/2011 |
| | the back of the fi | e threshold. Four fans at reezer had accumulated ere were four stacks of | | | new policy and procedure regarding handwashing and gloves will be instituted. Die staff will be in-serviced on th | - | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|---|---|------------------------------|---------|------------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | | <u> </u> | F | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | NCOLN AVENUE | | |
| | NS HOME FOR THE | EAGED | | EVANS' | VILLE, IN47714 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · ` | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | | | DATE |
| | ~ | rectly on the floor. | | | new handwashing and glove policy and procedure. Dietar | | |
| | | e bought boneless | | | staff will also be required to | y | |
| | 1 | were observed in a plastic | | | complete a post in-service te | est. | |
| | bin on a shelf. T | The label indicated they | | | During the survey, ice build ι | ıp in | |
| | were to be used | or frozen by 12/8/10. | | | the freezer was noted. An | | |
| | There was a plas | stic container with whole | | | outside refrigeration contract was called and he evaluated | | |
| | frozen green, ye | llow, and red peppers, | | | freezer and the problem of ic | | |
| | loosely covered | with foil. There was no | | | build up. Parts had to be | - | |
| | | tainer. There was another | | | ordered. The contractor has | | |
| | plastic container | with whole peppers, | | | stated he will return on July | | |
| | 1 - | with foil, with a label | | | 2011 to make the repair. Ong | joing | |
| | dated 6/26/10. | , | | | monitoring for one year. | | |
| | | | | | | | |
| | The Dietary Serv | vice Manager [DSM] was | | | | | |
| | _ | 6/9/11 at 2:48 p.m. She | | | | | |
| | · · | d submitted maintenance | | | | | |
| | | | | | | | |
| | | e build-up in the freezers | | | | | |
| | | so. She indicated the | | | | | |
| | I - | a lot of donated foods | | | | | |
| | 1 | ; a nun and another | | | | | |
| | 1 | ely went to the businesses | | | | | |
| | | e donations. She | | | | | |
| | | I not have a written policy | | | | | |
| | | e the donated food, i.e. | | | | | |
| | | ported and what to save | | | | | |
| | and what to disc | ard. She indicated she | | | | | |
| | didn't have a foo | d storage policy, but the | | | | | |
| | items with dates | 12/10 and 6/10 should | | | | | |
| | have been discar | ded. | | | | | |
| | 2. During the ob | oservation of the evening | | | | | |
| | meal, on 06/08/11 beginning at 6:00 P.M., | | | | | | |
| | | pers were observed | | | | | |
| | | while delivering meals | | | | | |
| | | n the dining room. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | A. BUII | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 06/14/2011 | |
|--------------------------|--|--|---------|--|---|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | apply gloves, retribuffet line and de resident. Dietary observed to retur her gloved hands another tray, and random resident. was not observed her gloves and persident. Dietary Employed apply gloves, retribuffet line and de resident. Dietary observed to retur her forehead with another tray, and random resident. was not observed her gloves and persident was not observed her gloves and persident was not observed her gloves and persident was then observed her gloves and persident was then observed and deliver it to a #2 was then observed handles and persident ray, and random resident. | re #1 was observed to rieve a meal tray from the eliver it to a random a Employee #1 was then in to the tray line, wipe on her uniform, retrieve deliver it to another. Dietary Employee #1 at any time to remove erform hand hygiene. The #2 was observed to rieve a meal tray from the eliver it to a random a Employee #2 was then in to the tray line, wipe in a gloved hand, retrieve deliver it to another. Dietary Employee #2 I at any time to remove erform hand hygiene. The served to apply gloves, any from the buffet line in random resident. QMA erved to return to the tray oble residents' wheelchair conal clothing, retrieve deliver it to another. QMA #1 was not time to remove her gloves delivered. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | | (X2) MULTIPLE CC A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/14/2011 | | | |
|--|---|---|---|--|---------------------------------------|--|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | Manager [CDM] P.M., she indicat pass out trays." In an interview v at 2:00 P.M., she have a policy on 3.1-21(i)(2) | with the Certified Dietary, on 06/08/11 at 6:30 ed, "We wear gloves to with the DoN, on 06/13/11 indicated, "We do not gloves." | | | | | | |
| F0425 SS=E | residents, or obtai described in §483 facility may permit administer drugs it under the general nurse. A facility must proviservices (including accurate acquiring administering of all meet the needs of The facility must e of a licensed pharmonial pharmacy services Based on observate record review, the | and biologicals to its in them under an agreement in 75(h) of this part. The unlicensed personnel to if State law permits, but only supervision of a licensed wide pharmaceutical g procedures that assure the in, receiving, dispensing, and il drugs and biologicals) to each resident. In the munder of the provision of | F0425 | The facility adopted a new glucometer disinfectant policiburing the survey process e resident who had orders for | • | | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F359 06/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVENUE ST JOHNS HOME FOR THE AGED EVANSVILLE, IN47714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE consultation to ensure residents received accuchecks were given their own individual glucometer. Nurses and medications and medication monitoring in QMAs were in-serviced on June accordance with their needs and accepted 23, June 24, June 27, and will be practices, for 1 of 1 sampled resident who in-serviced on July 1, 2011, addressing glucose testing and required blood glucose checks (resident glucometer disinfecting. New #10), in the sample of 11, and 9 of 9 hires will be in-serviced during supplemental sample residents requiring orientation process on blood glucose checks (residents' #5, #2, glucometer testing and #40, #38, #39, #4, #36, #32, #21), in the alucometer disinfecting. Ongoing in-services will occur bi-annually. supplemental sample of 29. The facility Nurses and QMAs will be failed to ensure opened medications were monitored twice weekly regarding dated when opened, and expired treatment glucometer sanitation. Consulting supplies were discarded, for 2 of 3 facility pharmacist has reviewed the policy on glucometer testing and units observed (Holy Family unit, Jeanne disinfecting and will monitor staff Jugan unit). This deficient practice had monthly on performance of the potential to affect 27 of 27 residents disinfecting glucometer. The ADON and DON will monitor. residing on those two units. Ongoing monitoring for one year. Completed date: 07/08/11 Findings include: In-services will be held on July 7 and July 8, 2011 for nurses and 1. The medication pass observation began QMAs addressing dating medication bottles when opened on 06/08/11 at 11:35 A.M. and monitoring for expired drugs and treatments. The policy for OMA #1 was observed to retrieve a medication in storage in the glucometer from the medication cart, facility will be in-serviced. Pharmacy technicians audited all obtain 3 alcohol pads, and 1 lancet strip medication carts, treatment carts, and place these supplies on a blue tray. and medication storage areas for QMA #1 was then observed to take the expired drugs. Consultant supplies on the tray into the Room of pharmacist will monitor medication storage areas monthly Resident #5. QMA #1 was then observed for expired drugs and treatments. to place the tray on the bed of Resident Pharmacy technicians will audit #5, enter the bathroom of Resident #5 and medication carts every two perform handwashing for 10 seconds. months for expired drugs. The consultant pharmacist reviewed QMA #1 was then observed to apply

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 06/14/2011 | | | |
|--|--|--|---|---------------------|---|---------------------------|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | I | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE | |
| IAU | gloves and wipe alcohol pad. QM to wipe the finge alcohol prep pad on Resident #9 w gloves or perform #1 was then obsestrip to the finger a drop of blood. Observed to inser Optium EZ glucocheck blood sugar In an interview a indicated, "Her A QMA #1 was the gloves and perfor seconds. QMA # wipe the glucome and return it to the In an interview w she indicated, "To on this floor, [name of Resident glucometer for every page of the page of | the glucometer with an A #1 was then observed or of Resident #5 with an and perform a fingerstick without changing her ming hand hygiene. QMA erved to touch the test of Resident #5 to obtain QMA #5 was then to the test strip into an ometer [a machine to or]. It that time QMA #1 accucheck is 101." In observed to remove her rem handwashing for 10 1 was then observed to eter with an alcohol pad he medication cart. With QMA #1 at that time here are two Accuchecks me of Resident #5 and to #40]. There is one wery unit, they [Resident #40] shareThe next 5:30 P.M." | | IAU | the policy and procedure for medication storage in the far and consultant pharmacist services provider requireme The ADON and DON will mo Ongoing monitoring for one Completed date: 07/14/11 | cility nts. onitor. | DATE | |
| | QMA #1, when a protocol she indi | ew at that time with sked about the sanitizing cated "We are supposed cohol each time we use | | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUII | (X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING | | | (X3) DATE SURVEY COMPLETED 06/14/2011 | |
|---|--|---|--|---------------------|---|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | 00/14/2 | |
| (X4) ID PREFIX TAG | SUMMARY S (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | at 5:00 P.M. she inservice on the G glucometer that was what the same time, a observed posted cabinet door. The facility was to disbetween resident swabs. At 12:05 p.m. on | was used by QMA #1], it d one, we just don't have | | | | | |
| | indicated the faci | ility had been cited on the survey for not sanitizing | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | | E SURVEY PLETED | |
|--|--|--|-------------------|--|---|--------------------|--------------------|
| | | 15E359 | A. BUII B. WIN | LDING IG | | 06/14/ | 2011 |
| | PROVIDER OR SUPPLIER | | | STREET A | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL DESCRIPTION OF LIST DEPOTE STATE OF MATTERS | | | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | BE | (X5) COMPLETION |
| | glucometers betwindicated she had time and used the manufacturer's impolicy. At 1:00 p.m. on 6 a copy of the cleafacility's model a The instructions "Cleaning Your M Store your monit If the surface of you may clean it. Use a damp cloth Healthcare profecteaning solution 70% Alcohol, or On 6/9/11 at 9:30 interviewed. At the manual for the indicated it was a healthcare setting person. The Don the manufacturer the facility should | cy MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) veen residents. She I written the policy at that eir glucometer astructions to develop the 6/8/11, the DoN provided aning instructions for the and brand of glucometer. were as follows: Monitor or in its carrying case. your monitor gets dirty, and mild soap. ssionals: Acceptable s include 10% Bleach, | | | (EACH CORRECTIVE ACTION SHOULI | BE | |
| | indicated checked Control [CDC] w to find information | d the Centers for Disease yeb site and was unable on. She then indicated DC and spoke to a | | | | | |
| | representative. S | the was told to follow the ecommendations. She | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUII | (X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING | | | (X3) DATE SURVEY COMPLETED 06/14/2011 | | | |
|--|--|---|--|--|--|---------------------------------------|--------------------|--|--|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE | 100/14/2 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | 1 | ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD | | | | | |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | TAG | CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | COMPLETION DATE | | |
| | representative the 70% alcohol and using and were be enough, she was individual glucor was provided reg sanitizing solution. On 6/9/11 at 4:45 a list of residents blood sugar chec | the informed the CDC as instructions included that's what they were eing told it was not good told they should then get meters. No information sarding an appropriate in. 5 p.m., the DoN provided who routinely had their ked using a glucometer. sidents identified; she | | | | | | | |
| | own blood sugar glucometer. The identified on the Resident #10, and | the eleven checked her using her own ten [10] residents list were Sampled d Supplemental Sample #40, #38, #39, #4, #36, | | | | | | | |
| | the Holy Family was observed. T generic Pepto Bis | of the general 6/10/11 at 10:00 a.m., Unit medication room here were open bottles of smol, and Milk of bottles had not been dated | | | | | | | |
| | Unit treatment ro with treatment su There was a bottl | tour, the Jeanne Jugan oom was observed. A cart applies was observed. de of 70% alcohol with an f 09-10. The same unit's | | | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | (X3) DATE SURVEY COMPLETED 06/14/2011 | |
|--|---|--|--------|---------------|--|--------------------|
| | | 15E359 | B. WIN | | | 06/14/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| ST JOHN | IS HOME FOR THE | AGED | | | NCOLN AVENUE VILLE, IN47714 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | ` · | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE COMPLETION DATE |
| IAG | | | | IAG | | DATE |
| | medication room was observed. A bottle of Milk of Magnesia was observed | | | | | |
| | _ | vas no date when the | | | | |
| | • | pened. During interview | | | | |
| | | DoN indicated, the 70% | | | | |
| | alcohol was hous | | | | | |
| | | | | | | |
| | A census record, provided by the Director | | | | | |
| | of Nurses on 6/6/11 at 9:45 a.m., indicated there were 27 residents residing on the Holy Family and Jeanne Jugan Units. | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | 4. The policy an | • | | | | |
| | | age in the Facility [no | | | | |
| | | ed by the Director of 16/13/11 at 12:10 p.m. | | | | |
| | | ated the following: | | | | |
| | | d biologicals are stored | | | | |
| | | and properly, following | | | | |
| | | ecommendations or those | | | | |
| | of the supplier' | | | | | |
| | • • | s not limited to, outdated, | | | | |
| | · · · · · · · · · · · · · · · · · · · | deteriorated medications | | | | |
| | | ainers that are cracked, | | | | |
| | soiled, or withou | t secure closures are | | | | |
| | · · · · · · · · · · · · · · · · · · · | oved from stock, | | | | |
| | - | rding to procedures for | | | | |
| | - | sal, and reordered from | | | | |
| | | a current order exists." | | | | |
| | | age conditions are | | | | |
| | | nonthly basis and | | | | |
| | | taken if problems are | | | | |
| | identified." | | | | | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|--------------|---|-----------------------------|--------------------|
| | | 15E359 | B. WIN | IG | | 06/14/2 | 2011 |
| | PROVIDER OR SUPPLIER | | - | 1236 LI | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE | - | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | (X5) COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | | nt Pharmacist Services | | | | | |
| | 1 | ements policy and | | | | | |
| | ^ | te] was provided by the | | | | | |
| | | es on 6/13/11 at 12:10 | | | | | |
| | | and procedure included, | | | | | |
| | | ed to, the following: | | | | | |
| | I - | pharmacist provides | | | | | |
| | consultation on a | - | | | | | |
| | 1 ^ _ | macy services in the boration with facility | | | | | |
| | 1 | | | | | | |
| | staff, the consulta | | | | | | |
| | identify, communicate, address, and resolve concerns and issues related to the | | | | | | |
| | | | | | | | |
| | | maceutical services. | | | | | |
| | | it is not limited to: | | | | | |
| | _ | identification and | | | | | |
| | | dication-related issues, | | | | | |
| | | vention and reporting of | | | | | |
| | | s and the provision and | | | | | |
| | | se of medication-related | | | | | |
| | devices. | | | | | | |
| | -Assisting in the | | | | | | |
| | _ | nursing staff medication necluding infusion therapy | | | | | |
| | l | | | | | | |
| | | ation delivery and testing | | | | | |
| | devices, through | - | | | | | |
| | record reviews." | through medication | | | | | |
| | record reviews." | | | | | | |
| | "Specific activiti | esincludes, but is not | | | | | |
| | limited to: | csiiciuucs, vut is iiot | | | | | |
| | | edication storage areas at | | | | | |
| | | id the medication carts at | | | | | |
| | | | | | | | |
| | least quarterly, fo | or proper storage and | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CO A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/14/2011 | | |
|--|--|---|---------------------------------------|--|----------------------|
| NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED | | | STREET 1236 L | ADDRESS, CITY, STATE, ZIP CODE INCOLN AVENUE SVILLE, IN47714 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | labeling of medic removal of expire | cations, cleanliness, and ed medications." | | | |
| | 3.1-25(e)(1) 3.1-25(o) | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI | | | URVEY | |
|---------------------------|--|---|--|---|--------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | | COMPLETED | |
| | | 15E359 | A. BUILDING | | | 06/14/2011 | |
| | | | | T ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF I | PROVIDER OR SUPPLIER | L | | LINCOLN AVENUE | | | |
| ST JOHN | IS HOME FOR THE | AGED | | ISVILLE, IN47714 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE | |
| F0441 SS=E | Infection Control F a safe, sanitary ar and to help prever transmission of dis (a) Infection Contr The facility must e Program under wh | stablish an Infection Control | | | | | |
| | infections in the fa (2) Decides what I isolation, should b resident; and (3) Maintains a red | • | | | | | |
| | determines that a prevent the spread must isolate the re (2) The facility mu communicable dis lesions from direct their food, if direct disease. (3) The facility mu hands after each of the spread o | ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted | | | | | |
| | transport linens so infection. A. Based on obstrecord review, the residents were sating nosocomial infections. | | F0441 | The facility adopted a new glucometer disinfectant polic During the survey process e resident who had orders for accuchecks were given their individual glucometer. Nurse | ach · own | 07/14/2011 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5LWB11 Facility ID:

000443

If continuation sheet Page 105 of 122

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|------------------------------|----------------------------------|----------|---|-----------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | 00 | COMPLETED | |
| | | 15E359 | B. WIN | IG | | 06/14/20 ⁻ | 11 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 1236 LINCOLN AVENUE | | | | |
| ST JOHN | IS HOME FOR THE | AGED | | EVANS | VILLE, IN47714 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | #5, Resident #36 |] who were observed to | | | QMAs were in-serviced on J | | |
| | have their blood | sugar checked per | | | 23, June 24, June 27, and w in-serviced on July 1, 2011, | ili be | |
| | glucometer, in th | e supplemental sample of | | | addressing glucose testing a | nd | |
| | 29, in that glucor | neters were not sanitized | | | glucometer disinfecting. New | | |
| | l - | s. This deficient practice | | | hires will be in-serviced durir | | |
| | | to affect 10 residents | | | orientation process on | | |
| | _ | ented to have glucometer | | | glucometer testing and | | |
| | | · · | | | glucometer disinfecting. Ong | | |
| | checks ordered p | • | | | in-services will occur bi-annu Nurses and QMAs will be | ially. | |
| | 1 * * | n a facility census of 42. | | | monitored twice weekly rega | rding | |
| | [sampled resident #10, supplemental | | | | glucometer sanitation. Const | - 1 | |
| | sample Residents | s #5, #2, #40, #38, #39, | | | pharmacist has reviewed the | ~ | |
| | #4, #36, #32, #21 | 1] | | | policy on glucometer testing | | |
| | | | | | disinfecting and will monitor | staff | |
| | | | | | monthly on performance of | | |
| | B. Based on obs | ervation, interview and | | | disinfecting glucometer. The | | |
| | | e facility failed to ensure | | | ADON and DON will monitor Ongoing monitoring for one y | | |
| | l | n when needed, to ensure | | | Completed date: 07/08/11 | ,cai. | |
| | - | | Mandatory in-services were held | | | | |
| | ~ | nged and hands washed | on June 14 and June 20, 2011 for | | | | |
| | | nd clean tasks, to ensure | all nursing employees addressing | | | | |
| | | ed for a sufficient length | | | policies and procedures for | | |
| | · · | are observations by | | | correct handwashing techniq | | |
| | facility staff for 5 | of 5 sampled residents, | | | Nursing staff will be monitore | | |
| | in the sample of | 11 (Residents #41, #29, | | | correct handwashing techniq five times weekly for one mo | | |
| | #12, #5, #30), an | d for 1 of 1 supplemental | | | Monitoring will continue twice | | |
| | | in the supplemental | | | weekly for randomly selected | | |
| | sample of 29 (Re | | | | employees. All new nursing | | |
| | F (110 | /- | | | employees will be in-serviced | | |
| | Findings include: | - | | | correct handwashing techniq | ues | |
| | i mamga merade. | | | | during orientation. Ongoing | ually | |
| | A 1 TT1 1' | | | | in-services will occur bi-annu The ADON and DON will mo | · 1 | |
| | | tion pass observation | | | Ongoing monitoring for one | | |
| | began on 06/08/1 | 1 at 11:35 A.M. | | | Completed date: 06/30/11 | , | |
| | | | | | In-services were held on Jun | ie 14, | |
| | - | served to retrieve a | | | June 20, June 23, June 27, a | | |
| | glucometer from | the medication cart, | | | will be held on July 1, 2011, | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | (X2) MULTIPLE CONSTRUCTION OO | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|------------------------------|--|---------------------------|--|----------------------------|------------|--|
| MINDILMIN | or conduction | 15E359 | - 1 | A. BUILDING | | | 06/14/2011 | |
| | | 102000 | B. WIN | | | 00/14/2 | | |
| NAME OF | PROVIDER OR SUPPLIE | 2 | | 1 | DDRESS, CITY, STATE, ZIP CODE | | | |
| ST JOHN | NS HOME FOR THE | E AGED | 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID | CHMMADV | STATEMENT OF DEFICIENCIES | | ID | · | | (X5) | |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | | TAG CROSS-REF | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | DATE | |
| | obtain 3 alcohol | pads, and 1 lancet strip | | | regarding correct glove usag | e | | |
| | | supplies on a blue tray. | | | and procedures. Proper glov | | | |
| | | en observed to take the | | | usage will be monitored five | times | | |
| | | ray into the Room of | | | a week for one month. | | | |
| | | - - | | | Monitoring will continue twice weekly for randomly selected | | | |
| | 1 | MA #1 was then observed | | | employees. All new employe | | | |
| | 1 ^ - | the bed of Resident #5, | | | will be in-serviced on proper | | | |
| | | om of Resident #5 and | | | usage during orientation. | | | |
| | _ | shing for 10 seconds. | | | Ongoing in-service will be he | | | |
| | QMA #1 was then observed to apply gloves and wipe the glucometer with an | | | | bi-annually. The ADON and I will monitor. Ongoing monito | | | |
| | | | | | for one year. Completed dat | | | |
| | alcohol pad. QMA #1 was then observed | | | | 07/08/11 Mandatory in-service | | | |
| | to wipe the finger of Resident #5 with an | | | | were held for all nursing | | | |
| | alcohol prep pad and perform a fingerstick | | | | employees on June 14 and J | | | |
| | on Resident #5, | without changing her | | | 20, 2011 addressing peri and | | | |
| | gloves or perform | ming hand hygiene. QMA | | | incontinence care procedure | | | |
| | #1 was then obse | erved to touch the test | | | CNAs will be monitored prov peri-care five times a week for | | | |
| | strip to the finge | r of Resident #5 to obtain | | | one month. Monitoring will | | | |
| | | QMA #1 was then | | continue twice weekly for | | | | |
| | 1 ^ | rt the test strip into an | randomly selected employees. All new employees will be in-serviced | | | | | |
| | | ometer [a machine to | | | | | | |
| | check blood sug | _ | | | on peri- care during the orientation process and ongo | nina | | |
| | encon oroon sug | ···]. | | | bi-annual in-servicing addres | - | | |
| | In an interview of | at that time, QMA#1 | | | peri-care will occur. The char | | | |
| | | Accucheck is 101." | | | nurse, ADON and DON will | | | |
| | indicated, Tier A | Accuences is 101. | | | monitor. Ongoing monitoring | | | |
| | OMA #1 was the | on absorved to someone bos | | | one year. Completed 06/30/ In-services will be held on Ju | | | |
| | ` | en observed to remove her | | | and July 8, 2011 addressing | 'y ' | | |
| | | orm handwashing for 10 | | | medication administration an | d | | |
| | | 1 was then observed to | | | infection control. The facility's | s | | |
| | | eter with an alcohol pad | | | policy and procedure for | اما | | |
| | and return it to the | he medication cart. | | | medications will be in-service Nurses and QMAs will be | eu. | | |
| | | | | | monitored daily for one mont | h. | | |
| | | with QMA #1, at that | | | and then twice weekly for co | | | |
| | time, she indicat | ed, "There are two | | | medication administration an | d | | |
| | Accuchecks on t | his floor, [name of | | | infection control. New hires v | vill be | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | | A. BUIL | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING B. WING (X3) DATE SU COMPLE 06/14/20 | | ETED | | |
|---|---|---|--|---------------------|--|-----------|----------------------------|
| | PROVIDER OR SUPPLIE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | I | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| TAG | Resident #5 and There is one gluthey [Resident # shareThe next P.M." During an interve QMA #1, when a protocol, she indicated to clean it with a it." In an interview wat 5:00 P.M., she inservice on the glucometer that is just like the oldoto reprogram like to reprogram like A2. On 6/8/11 a observed using a medication cart is blood sugar. Up procedure, she to thoroughly wipe machine. On 6/8/11 at 12: interviewed. She more blood glucy queried about used is infect the gluthat was what the share is one glucy with the share of the gluthat was what the share is one glucy with the share of the gluthat was what the share is one glucy in the share of the gluthat was what the share of the share of the gluthat was what the share of the gluthat was what the share of the share of the share of the gluthat was what the share of the sh | name of Resident # 40]. cometer for every unit, 5 and Resident #40] Accucheck is at 5:30 iew, at that time, with asked about the sanitizing licated, "We are supposed lcohol each time we use with the DoN, on 06/08/11 e indicated, "We did not Optium EZ [the was used by QMA #1], it d one, we just don't have | | TAG | in-serviced during orientation ongoing in-service will occur bi-annually. Consultant pharmacist will perform medication administration remonthly for three months and then quarterly. The ADON ard DON will monitor. Ongoing monitoring for one year. Completed date: 07/14/11 | view d | DATE |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE COMPI 06/14/2 | LETED | |
|---|--|---|--------|---------------------|---|-------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) | E | (X5) COMPLETION DATE |
| | cabinet door. The facility was to dis | on the medication room e policy indicated the sinfect the glucometers s with 70% alcohol | | | | | |
| | Nurses [DoN] wa indicated the faci previous annual s glucometers betw indicated she had time and used the | 6/8/11, the Director of as interviewed. She lity had been cited on the survey for not sanitizing ween residents. She written the policy at that eir glucometer astructions to develop the | | | | | |
| | a copy of the clear facility's model at The instructions of the instructions of the instructions of the instructions of the instructions of the instructions of the instruction of the i | Monitor or in its carrying case. your monitor gets dirty, and mild soap. ssionals: Acceptable s include 10% Bleach, | | | | | |
| | interviewed. At the manual for the indicated it was a | a.m., the DoN was that time, she provided e facility's glucometer. It appropriate to use in gs for more than one | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|---|----------------------|--|------------|--------------|--|-----------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 15E359 | A. BUII | LDING | 00 | COMPL: 06/14/20 | |
| | | 100009 | B. WIN | | | 00/14/20 | J11 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST IOHN | IS HOME FOR THE | AGED | | 1 | NCOLN AVENUE VILLE, IN47714 | | |
| | | | | | VILLE, IIVT// 17 | | (M2) |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | DATE |
| _ | | N indicated she had called | | - | | | |
| | - | and they had indicated | | | | | |
| | | d follow the instructions | | | | | |
| | _ | cleaning. The DoN | | | | | |
| | | d the Centers for Disease | | | | | |
| | | veb site and was unable | | | | | |
| | | on. She then indicated | | | | | |
| | | OC and spoke to a | | | | | |
| | | She was told to follow the | | | | | |
| | • | ecommendations. She | | | | | |
| | | he informed the CDC | | | | | |
| | | e instructions included | | | | | |
| | • | that's what they were | | | | | |
| | | eing told it was not good | | | | | |
| | _ | told they should then get | | | | | |
| | _ | neters. No information | | | | | |
| | | garding an appropriate | | | | | |
| | sanitizing solution | | | | | | |
| | Summizing solution | | | | | | |
| | On 6/9/11 at 4·45 | 5 p.m., the DoN provided | | | | | |
| | | who routinely had their | | | | | |
| | | ked using a glucometer. | | | | | |
| | _ | sidents identified; she | | | | | |
| | | the eleven checked her | | | | | |
| | own blood sugar | | | | | | |
| | _ | ten residents identified | | | | | |
| | _ | sugar checks done by the | | | | | |
| | _ | following: sampled | | | | | |
| | _ | plemental sample | | | | | |
| | | , #40, #38, #39, #4, #36, | | | | | |
| | #32, #21. | , , ,,, ,,, | | | | | |
| | - , | | | | | | |
| | | | | | | | |
| | B1. On 6/7/11 at | t 8:40 a.m., CNA #3 was | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | |
|---|---|---|------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | · | 1236 LI | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤΕ | (X5) COMPLETION DATE |
| | bathroom. When Resident #41, sh then assisted Resident #29's row #4 assisted Resident #29's row #4 assisted Residents. CNA #3 and CN assisted Resident using a sit to start the toilet. CNA pull-up type brief the soiled brief in resident had a bositting on the toil gloves, wiped the paper. With the the clean brief and Then she took the the soiled items as soiled utility room hands. B2. On 6/8/11 and #2 were observed to the bathroom assist. A pull-up type brief the soiled items as soiled utility room hands. | er room. She then went to from. CNA #3 and CNA dent #29 to the bathroom. They taked her hands between the weak and placed her on the weak and the resident's from the weak and took them to the the weak and took them to the the weak and took them to the the weak and the weak and the weak and the weak and the weak and the weak and soiled the weak and | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE (COMPL 06/14/2 | ETED | |
|---|---------------------------------------|--|--------------|----------------|---|------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIEI | ! | | | DDRESS, CITY, STATE, ZIP CODE | ! | |
| | IS HOME FOR THE | | | | NCOLN AVENUE VILLE, IN47714 | | |
| | | STATEMENT OF DEFICIENCIES | | ID | VILLE, IIN+11 14 | | (V.5) |
| (X4) ID PREFIX | | ICY MUST BE PERCEDED BY FULL | ₁ | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | · ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | DATE |
| | After giving the resident time on the | | | | | | |
| | toilet, CNA #2 v | vashed the resident's | | | | | |
| | 1 ^ | reaching through the legs | | | | | |
| | | nd, using wash cloths, | | | | | |
| | washing the area | from back to front. | | | | | |
| | The policy of 1 | proceedure for Derinant | | | | | |
| | 1 ^ ^ ^ | orocedure for Perineal 05, indicated the purpose | | | | | |
| | • | s "to clean the perineum, | | | | | |
| | provide comfort | | | | | | |
| | | procedure included, but | | | | | |
| | | to, the following: "wash | | | | | |
| | | of vulva downward and | | | | | |
| | rinse." | | | | | | |
| | | | | | | | |
| | | n observation of the | | | | | |
| | | on 06/08/11 at 12:00 | | | | | |
| | · · | icated she was preparing | | | | | |
| | | edications and feeding | | | | | |
| | i infough a gasifo | stomy tube [g-tube]. | | | | | |
| | RN #1 entered t | he room of Resident #12 | | | | | |
| | | served to enter the | | | | | |
| | resident's bathro | om and perform | | | | | |
| | handwashing for | 10 seconds. RN #1 was | | | | | |
| | then observed to | apply gloves. RN #1 | | | | | |
| | was then observe | ed to be unable to obtain a | | | | | |
| | residual of feedi | ng. RN #1 was then | | | | | |
| | | ove gloves, perform | | | | | |
| | _ | 8 seconds, and exit the | | | | | |
| | | as then observed to | | | | | |
| | 1 | n, enter the bathroom and | | | | | |
| | _ | shing for 5 seconds. | | | | | |
| | RN#1 was then | observed to apply gloves | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ULTIPLE CO LDING | INSTRUCTION 00 | (X3) DATE S COMPL | | |
|---|---|--|---------------------|----------------|--|---------|--------------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| | PROVIDER OR SUPPLIER | | 1 | STREET A | ADDRESS, CITY, STATE, ZIP CODE NCOLN AVENUE VILLE, IN47714 | 1 | |
| | | | | | VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` · | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| IAG | | ESC IDENTIFFING INFORMATION) | - | IAU | | | DATE |
| | • | ister medications and a | | | | | |
| | bolus feeding through the g-tube of Resident #12. | | | | | | |
| | | of the procedure, RN #1 | | | | | |
| | | remove her gloves and | | | | | |
| | - | shing for 10 seconds. RN erved to apply gloves and | | | | | |
| | | with a paper towel. RN | | | | | |
| | | erved to remove gloves | | | | | |
| | | dwashing for 10 seconds. | | | | | |
| | - | observed to apply gloves | | | | | |
| | | away. RN #1 was then | | | | | |
| | | ove gloves and perform | | | | | |
| | handwashing for | | | | | | |
| | | vith RN #1, at that time, | | | | | |
| | she indicated that washed frequently | t hands were to be ly. | | | | | |
| | In an interview w | with the DoN, on 06/08/11 | | | | | |
| | at 4:30 P.M., she | indicated, "We just | | | | | |
| | inserviced onh | andwashing." | | | | | |
| | | ved administering | | | | | |
| | | esident #12 through a | | | | | |
| | | on 6/8/11 at 5:50 p.m. | | | | | |
| | _ | medications to the room | | | | | |
| | _ | e tray. She wore gloves. | | | | | |
| | Prior to the admi | | | | | | |
| | | removed the dressing | | | | | |
| | _ | e entry site. It was soiled | | | | | |
| | with light beige s | solution and a small | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|--|----------------------|--|------------|--------------|--|------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 15E359 | A. BUII | LDING | 00 | COMPL 06/14/2 | |
| | | 100009 | B. WIN | | | 00/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST IOHN | IS HOME FOR THE | AGED | | | NCOLN AVENUE VILLE, IN47714 | | |
| | | | | | VILLE, IN477 14 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| TAG | 1 | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| 1710 | | h-red splotches. She | | 1710 | | | DATE |
| | 1 | syringe to the end of the | | | | | |
| | | ster the medications. No | | | | | |
| | - | hand washing was done. | | | | | |
| | - | o get any residual feeding | | | | | |
| | | d had to leave the room to | | | | | |
| | | s. She took off her | | | | | |
| | | ot wash her hands. | | | | | |
| | gioves, but did no | ot wash her hands. | | | | | |
| | When she return | ed to the room, she put | | | | | |
| | on another pair o | • • | | | | | |
| | | medications and a can of | | | | | |
| | | through the g-tube. With | | | | | |
| | _ | she used wound wash | | | | | |
| | _ | | | | | | |
| | | around the g-tube site | | | | | |
| | 1 . | . She then dried the area | | | | | |
| | 1 . | and applied a clean | | | | | |
| | " | ne same gloves. The | | | | | |
| | syringe used to a | | | | | | |
| | | feeding had been placed | | | | | |
| | | y. She briefly rinsed the | | | | | |
| | | ed it back in a container | | | | | |
| | | he removed her gloves | | | | | |
| | | ray out of the room and to | | | | | |
| | the medication ro | oom. | | | | | |
| | In the mediantics | n room, RN #2 was | | | | | |
| | | in hand soap from the | | | | | |
| | | • | | | | | |
| | _ | nd wash the plastic tray at | | | | | |
| | uie same ume sn | e was washing her hands. | | | | | |
| | R3 During the r | medication pass, on | | | | | |
| | | n., RN #1 was observed | | | | | |
| | _ | | | | | | |
| | aummistering me | edications to Resident | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPL A. BUILDING | E CONSTRUCTION 00 | C | DATE SURVEY OMPLETED /14/2011 | |
|--|----------------------|-------------------------------|--------------------|-------------------------------------|---|------------|
| | | 15E359 | B. WING | | | /14/2011 |
| NAME OF I | PROVIDER OR SUPPLIER | | l l | EET ADDRESS, CITY, STA | | |
| ST JOHN | IS HOME FOR THE | AGED | | 6 LINCOLN AVENU NSVILLE, IN47714 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | ppovinep's i | PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PREFI | (EACH CORRECTIV | VE ACTION SHOULD BE CED TO THE APPROPRIATE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEF | FICIENCY) | DATE |
| | #30. She droppe | d a pill onto the | | | | |
| | | t, scooped up the pill | | | | |
| | with a spoon and | placed it in the resident's | | | | |
| | mouth. | | | | | |
| | B4. LPN #2 was | s observed, on 06/08/11 at | | | | |
| | 11:50 A.M., to a | dminister insulin to | | | | |
| | Resident #5. LP | N #2 was observed to | | | | |
| | | sulin without applying | | | | |
| | gloves. In an inte | erview at that time LPN | | | | |
| | #2 indicated, "I f | orgot to wear my gloves." | | | | |
| | LPN #2 was then | observed to perform | | | | |
| | handwashing and | l while drying her hands, | | | | |
| | LPN #2 was obse | erved to drop a paper | | | | |
| | towel on the floo | r, retrieve it, and use it to | | | | |
| | continue drying l | ner hands. LPN #2 was | | | | |
| | not observed to s | anitize her hands after | | | | |
| | using the droppe | d paper towel to dry her | | | | |
| | hands. | | | | | |
| | A policy and pro | cedure for Handwashing, | | | | |
| | dated 05/2006, p | rovided by the DoN on | | | | |
| | 06/08/11 at 5:15 | P.M., indicated, "Policy | | | | |
| | All staff providing | ng direct patient care or | | | | |
| | having any physi | cal contact with resident | | | | |
| | or their equipmen | nt shall wash their hands | | | | |
| | | will include, but is not | | | | |
| | | etween contact with | | | | |
| | different Residen | nt | | | | |
| | 3. Before and af | ter any physical contact | | | | |
| | with Resident eq | uipment or personal | | | | |
| | article Before a | and after any procedure | | | | |
| | with Resident7 | . After the removal of | | | | |
| | gloves Procedu | re2. lather hands and | | | | |
| | rub vigorously fo | or ten to fifteen (10-15) | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMF 06/14/ | LETED | |
|--|---|--|---------------------|--|---------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1236 LI | ADDRESS, CITY, STATE, ZIP CO NCOLN AVENUE VILLE, IN47714 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | Prevention documents of Clean Hands Save DoN on 06/13/1 "What is the right hands? Wet your together to make | Disease Control and ment, "Handwashing: ve Lives," provided by the 1 at 2:25 P.M., indicated, at way to wash your handsrub your hands a lather and scrub them rubbing your hands for at" | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E359 | | (X2) MU A. BUILI B. WING | DING | NSTRUCTION 00 | (X3) DATE S COMPL 06/14/2 | ETED | |
|---|---|---|---------|---------------------|--|---|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WING | STREET A | NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | F | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Έ | (X5) COMPLETION DATE |
| F0520 SS=F | and assurance condirector of nursing designated by the members of the fa. The quality assess committee meets a issues with respectassessment and a necessary; and deappropriate plans identified quality described assessment and a text of the Section of the respectation of the compliance of requirements of the Good faith attemption identify and correct be used as a basis Based on record facility failed to assessment and a | sment and assurance at least quarterly to identify to which quality ssurance activities are evelops and implements of action to correct efficiencies. Cretary may not require ecords of such committee such disclosure is related to such committee with the is section. | F05 | 520 | An in-service was held on Ju 27 and June 29, 2011 for members of the QA committe reviewing the facility's QA po and procedures. The ADON | ee licy | 07/05/2011 |
| | correct deficience place for on-goin corrective action. | This deficient practice to affect all 42 residents | | | is the QA Coordinator, was in-serviced on June 27, 2011 the responsibilities of the QA Coordinator. The Medical Dir reviewed the QA policy and procedures on June 29, 2017 The QA Committee will contint to meet quarterly to identify qualities and deficiencies and implement appropriate plans corrective action. When indicathe QA committee will development. | on rector I. nue d of ated, | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE : COMPL | | |
|--|----------------------|------------------------------|------------|------------|--|---------|------------|
| AND PLAN | OF CORRECTION | 15E359 | A. BUI | LDING | 00 | 06/14/2 | |
| | | 10000 | B. WIN | | | 00/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHN | IS HOME FOR THE | AGFD | | 1 | NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | DATE |
| | On 6/10/11 at 11: | :15 a.m., the Director of | | | ongoing monitoring system v | vhere | |
| | Nurses [DoN] wa | as interviewed regarding | | | as the medical staff and anci | - | |
| | the facility's Qua | lity Assessment and | | | personnel will be able to ider and improve problem areas | ntity | |
| | Assurance Progra | am [QAA]. She | | | impacting directly or indirectl | y on | |
| | indicated the faci | ility did have a program | | | resident care. The next QA | - | |
| | and the Assistant | Director of Nursing | | | meeting will be in July 2011. | | |
| | | eetings. The current | | | QA program will be reviewed quarterly by the QA Committ | | |
| | Assistant Directo | or of Nursing had only | | | ensure that the program is | | |
| | been employed for | or a few weeks, so she | | | comprehensive and effective | | |
| | had not been invo | olved in QAA yet. The | | | improving resident care. The | : QA | |
| | former Assistant | Director of Nurse had | | | plan will be approved by the medical staff, the administrat | or | |
| | been gone for 3-4 | 4 weeks. The committee | | | and governing body. The | .01, | |
| | consisted of the I | Director of Nurses, the | | | administrator and the DON w | | |
| | Assistant Directo | or of Nurses, Social | | | monitor. Ongoing monitoring | for | |
| | Services, Activiti | ies, the President of the | | | one year. | | |
| | facility, the Medi | ical Director, | | | | | |
| | Housekeeping Su | apervisor, Maintenance | | | | | |
| | Director, Pharma | icist, Human Resources | | | | | |
| | Director, Dietary | Manager. She indicated | | | | | |
| | they met quarterl | y. | | | | | |
| | | | | | | | |
| | The DoN indicate | ed they had certain | | | | | |
| | 1 | ewed, for example | | | | | |
| | l | , safety, pharmacy | | | | | |
| | | es. When queried how | | | | | |
| | the committee de | etermined issues for the | | | | | |
| | Quality Assessme | ent and Assurance | | | | | |
| | Committee [QAA | A] to follow, she | | | | | |
| | | eally don't have anything | | | | | |
| | | no problems." She further | | | | | |
| | indicated they re- | viewed infections, | | | | | |
| | incidents/acciden | nts, employee safety, as | | | | | |
| | | hen queried about | | | | | |
| | contracted servic | es being part of the QAA | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE : COMPL | | |
|---|----------------------|---|------------|--------------|--|---------|--------------------|
| AND PLAN | OF CORRECTION | 15E359 | A. BUI | LDING | 00 | 06/14/2 | |
| | | 10000 | B. WIN | | | 00/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST IOHN | IS HOME FOR THE | AGED | | | NCOLN AVENUE VILLE, IN47714 | | |
| | _ | | | | VILLE, IINT// IT | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | | herapy, she indicated it | | | | | |
| | was not on their | 10, | | | | | |
| | was not on then | agenda. | | | | | |
| | The DoN indicat | ed issues were | | | | | |
| | | ne minutes and discussed | | | | | |
| | | She indicated the same | | | | | |
| | · · | wed each meeting. The | | | | | |
| | | to describe the process | | | | | |
| | | o end using an example | | | | | |
| | 1 | en queried about the | | | | | |
| | | e indicated they always | | | | | |
| | _ | nift and what time people | | | | | |
| | | ry to find out why they | | | | | |
| | | e indicated other than | | | | | |
| | evaluating the tre | | | | | | |
| | | had been initiated. | | | | | |
| | corrective action | nad occii initiated. | | | | | |
| | The Ouality Assu | rance-Improvement | | | | | |
| | 1 . | and procedure, dated | | | | | |
| | 5/2006, was prov | rided by the DoN on | | | | | |
| | 6/13/11 at 12:10 | p.m. The Purpose of the | | | | | |
| | policy included t | he following: | | | | | |
| | "1. To identify q | ualities, deficiencies and | | | | | |
| | implementing ap | propriate plans of | | | | | |
| | corrective action | | | | | | |
| | 2. To develop a | comprehensive QA | | | | | |
| | program that will | l apply to all | | | | | |
| | | vices and practitioners in | | | | | |
| | the home in an et | ffort to maintain high | | | | | |
| | quality patient ca | ire. | | | | | |
| | | integrated approach to | | | | | |
| | the QA Program. | | | | | | |
| | 4. To develop an | on-going monitoring | | | | | |
| | system whereby | the Governing Body | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: | | | IULTIPLE CO LDING | NSTRUCTION 00 | (X3) DATE : | ETED | |
|--|----------------------|------------------------------|----------------------|---------------|--|---------|------------|
| | | 15E359 | B. WIN | | | 06/14/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| ST JOHN | IS HOME FOR THE | AGED | | | NCOLN AVENUE VILLE, IN47714 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΤE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | 1 | Medical Staff and | | | | | |
| | 1 - | nel will be able to | | | | | |
| | | rove problem areas | | | | | |
| | 1 ^ ~ | y or indirectly on patient | | | | | |
| | care." | | | | | | |
| | D 333 | | | | | | |
| | | included, but were not | | | | | |
| | limited to, the fo | · · | | | | | |
| | Department Head | | | | | | |
| | | quality of care they | | | | | |
| | 1 ^ | tablish criteria to | | | | | |
| | monitor their ser | | | | | | |
| | 1 ^ | ty for meeting all QA | | | | | |
| | activities shall be | - | | | | | |
| | 1 ^ | s and reports shall be | | | | | |
| | | QA Coordinator upon | | | | | |
| | request." | | | | | | |
| | QA Committee: | | | | | | |
| | 1 ^ | nechanism for the | | | | | |
| | organized, object | | | | | | |
| | evaluation of Res | | | | | | |
| | | comprehensive QA | | | | | |
| | 1 ~ | ng medical, nursing, and | | | | | |
| | other ancillary su | • • | | | | | |
| | | ropriateness of topics and | | | | | |
| | validity of criteri | | | | | | |
| | _ | roblems identified | | | | | |
| | | vities are addressed and | | | | | |
| | solved in a timely | | | | | | |
| | QA Coordinator: | | | | | | |
| | "Keep up-to-date | on quality assurance. | | | | | |
| | Review changes | with the Committee and | | | | | |
| | making recomme | endations geared toward | | | | | |
| | meeting regulation | ons and standards." | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|---|---|---|-------------------------------------|-------------------------------|----------------------------|--|--|
| | | 15E359 | B. WIN | | | 06/14/2011 | | | |
| NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE | | (X5) COMPLETION DATE | | |
| | "Develop and inito carry out qualitas instructed by to "Develop and instatistical profile. Committee to assignative of care." "Coordinate devestudies, solicit to screening criteria interdepartmenta "To monitor the intercommendation." Regarding Problem shall from an expected be justified as ap "All studies will deal with suspect areas where the phigh." "The problem that affect on Resider." Regarding Problem that affect on Resider. tiate effective procedures ty assessment activities he Committee." stitute methods to provide and other data to the sist in evaluation of elopment of evaluation pics, help design and facilitate l participation." implementation of s for corrective action." em Identification: be defined as a deviation l occurrence that may not propriate." be problem-oriented and ted problems or focus on potential for problems is at has the most adverse at care will have priority." em Assessment: will be used to assess measure achievable teria may be related to me, to standards of rofessional organizations, eloped within the home." led that studies be | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011 FORM APPROVED OMB NO. 0938-0391

| | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COM | (X3) DATE SURVEY COMPLETED 06/14/2011 | | |
|--------------------------|------------------------------|---|---|--|---------|---------------------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| | 3.1-52(b)(1) 3.1-52(b)(2) | | | | | | | |